Guidelines for the Use of Restraint or Containment in Enhanced Behavioral Supports Homes

California Department of Developmental Services
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Table of Contents

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Background

The Department of Developmental Services (Department) is committed to providing the services and supports needed for individuals with developmental disabilities to live in the least restrictive settings. Welfare and Institutions Code (WIC) §4684.81(i)(1) requires the Department to develop guidelines regarding the use of restraint or containment in Enhanced Behavioral Supports Homes (EBSHs), which are to be maintained in the facility program plan and plan of operation. In the development of these guidelines, the Department consulted with appropriate professionals regarding the use of restraint or containment in enhanced behavioral supports homes and with Disability Rights California regarding appropriate safeguards for the protection of individuals' rights.

The purpose of these Guidelines, although primarily to provide guidance to EBSH providers regarding the use of restraint or containment, is multifaceted. The ability to manage a behavioral crisis is critically important for all staff who work with individuals living in EBSHs, including direct support professionals (DSPs), consultants and administrators. All staff must receive training regarding how to manage crisis situations, including the use of restraint as an emergency measure of last resort when the risk of serious harm to self or others is imminent. However, with the goal of minimizing and avoiding the use of restraint, staff must also be skilled in preventing conflict and crisis situations from initially occurring.

> *Individuals who receive services designed to change behavior have the right to a therapeutic environment, services which focus on personal welfare, treatment by a competent behavior analyst, programs which emphasize the development of functional skills, behavioral assessment and ongoing evaluation, and the most effective treatment procedures available (VanHouten, et al., 1988).*

Accordingly, these Guidelines also focus on maintaining individual dignity and rights through the use of preventative, proactive strategies to avoid a crisis and on the use of less restrictive, non-physical reactive strategies in response to a crisis, should one occur. The Guidelines summarize laws and regulations around the use of restraint or containment as well as laws and regulations regarding the general provision of services in EBSHs, including those relevant to Individual Behavior Supports Plans, Functional Behavior Assessments, facility and Individual Emergency Intervention Plans, staff training, data collection, monitoring and reporting.

Although restraint may be part of an emergency intervention plan; it is never a substitute for a comprehensive behavior support plan that is person-centered, trauma-informed and embraces a positive behavior supports approach. Within a positive behavior supports framework, individuals are supported in changing behaviors that (a) pose a health and safety risk for themselves or others, (b) interfere with their personal relationships, (c) interfere with their growth as individuals, (d) interfere with their decision-making abilities, and/or (e) result in being prescribed behavior-modifying medications. Positive behavior supports strive to support an individual's personal development, enhance quality of life and avoid the use of restrictive and punitive interventions.

Overview of Enhanced Behavioral Supports Homes

What are Enhanced Behavioral Supports Homes?

EBSHs are certified by the Department and licensed by the State Department of Social Services as adult residential facilities or group homes that provide 24-hour non-medical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike setting. The enhanced behavioral services and supports provided to address individuals' challenging behaviors include additional staffing supervision, facilities characteristics and other services and supports which are beyond what is typically available in other community-based adult residential facilities or group homes to serve individuals in a community setting rather than an institution. (WIC §4684.80(a) and (b))

What is the Underlying Goal of EBSHs?

The purpose of EBSHs is to provide intensive behavioral services and supports to adults and children with developmental disabilities who need intensive services and supports due to challenging behaviors that cannot be managed in a community setting without the availability of enhanced behavioral services and supports, and who are at risk of institutionalization or out-of-state placement, or are transitioning to the community from a developmental center, other state–operated residential facility, institution for mental disease, or out-of-state placement. (WIC §4684.81(a))

Within the context of person-centered practices, trauma-informed care and positive behavior supports, EBSHs support individuals in overcoming the barriers that interfere with their relationships among family and friends and with their successful integration as respected and contributing members of the community. Additionally, these enhanced supports provide the intensive services needed to support individuals during behavioral crises so the need for acute crisis services or admission to acute psychiatric facilities or institutions for mental disease is minimized or prevented.

Individual Behavior Supports Plans and Functional Behavior Assessment

Individual Behavior Supports Plans
• Developed within one week of an individual's move to EBSH • Reviewed at least monthly by the Individual Behavior Supports Team • Administrator submits IBSP and updates to regional center service coordinator and clients' rights advocate, when applicable • Informed by the Functional Behavior Assessment • Function-based, evidence-based, functionally equivalent replacement behaviors targeted • Based on Person-Centered Planning, Positive Behavior Supports, Trauma Informed Care

Functional Behavior Assessments
• Completed by Qualified Behavior Modification Professional within 30 days of move to EBSH, with input from IBST • Informs Individual Behavior Supports Plan • Conforms to best practice standards

As per WIC §4684.83, an initial Individual Behavior Supports Plan (IBSP) must be developed with the person's Individual Behavior Supports Team (IBST, described in detail below) within one week of an individual's move into an EBSH. The IBSP identifies and documents the individual's intensive service and support needs with particular focus on difficult behaviors and details the strategies that will best meet the person's needs [WIC §4684.80(c), Health and Safety Code §1567.61(b)]. The Department recommends that the Qualified Behavior Modification Professional (QBMP) write the IBSP. Qualifications for QBMPs can be found in the Staff Training section of these Guidelines.

From a person-centered perspective, services and supports should address the balance between what is *important to* and what is *important for* a person. The idea of the balance between what is *important to* and what is *important for* a person is rooted in the human condition where none of us has a life where we have everything that is *important to* us and none of us pay perfect attention to everything that is *important for* us. All of us strive for a balance between them. Through a discovery and person centered planning process, which includes the FBA and IBSP, we are more likely to support people in reaching their potential when we work together with them and their loved ones to find that balance between what they need to have a more satisfying and happier life, what is important for their health and safety, and what others see as necessary to helping them be valued and contributing members of the community.

Behavior support plans used prior to the person moving to an EBSH may contain effective strategies, replacement skill trainings, and known antecedents that can be the best starting point for the initial IBSP. If, however, previous plans include restrictive interventions that are not allowed in EBSHs (e.g., mechanical restraint, seclusion), they cannot be included in the initial IBSP.

Successfully supporting a person with challenging behaviors begins by getting to know the person in a meaningful way. Within the first month of an individual's move into an EBSH, the effectiveness of the IBSP will need to be closely monitored and may be revised to add additional strategies or remove ineffective ones. Even when cross training opportunities exist with prior staff, individuals often change or react differently to situations after moving to a new home.

Within 30 days, as per Title 17 §59056(c)(1)-(2), a functional behavior assessment (FBA) must be done with input from the IBST and the IBSP must be updated to include relevant information from the FBA. If a FBA is conducted prior to the person moving in the EBSH, it should be updated within 30 days after the person moves to ensure the inclusion of new information as well as input from the IBST.

The IBST is to review the IBSP monthly and provide updated information as necessary (Title 17 §59054(c)). Revisions to the IBSP are likely as the person settles into the new home and establishes stronger relationships with peers and support staff. Over time, the IBSP is expected to even more accurately reflect the individualized services and supports the person needs to achieve health and well-being, develop and maintain relationships, increase participation in everyday community life and learn skills to cope with difficult situations in more productive ways.

The EBSH administrator is required to submit the IBSP and any updates to the regional center service coordinator (and vendoring regional center if the two are different) and, unless the individual objects on his or her behalf, to the regional center's clients' rights advocate, when applicable (Title 17 §59064(e)).

As per Title 17 §59054(d), the IBSP must be function-based, evidence-based, target functionally equivalent replacement behaviors, and include a description of the following:

- Baseline behaviors;
- Target behaviors and goals;
- Functions of behaviors;
- Desired outcomes/replacement behaviors;
- Intervention strategies, including antecedent strategies, instructional strategies and consequence strategies;
- Entity responsible;
- Environmental changes;
- Timelines/review dates;
- Data collection/monitoring progress/evaluation methods; and
- Emergency interventions that may be necessary.

Title 17 regulations regarding the conduct of FBAs and development of IBSPs should be viewed as the minimum standards. EBSH providers, in coordination with their QBMPs, must also look to best practice standards when conducting FBAs and developing IBSPs.

The FBA is the foundation for the IBSP. Given the enhanced behavioral supports, staffing and supervision required by individuals living in EBSHs, it must be comprehensive. Best practice in conducting a comprehensive FBA includes direct observation of the person, interviews with the person and significant others (e.g., family, friends, support staff and other interdisciplinary team members), and a review of available relevant information (e.g., assessment reports, incident reports, medical records).

Based on direct observation and the records reviewed, the FBA should include operational definitions of the target behaviors (e.g., behaviors of concern), including onset and offset criteria to ensure that data can be collected with fidelity and analyzed in a meaningful way. A hypothesis about the function(s) of the target behavior(s) should be based on an antecedent and consequence analysis as well as an environmental analysis that assesses the matches and mismatches in the individual's physical, interpersonal and service environments. The environmental analysis should consider factors, such as participation and interest in various activities, teaching strategies, routines and rituals, degree of choice and control, and the quantity and quality of relationships. Setting variables should also be included, such as physiological factors (e.g. dietary, menses, and other sensitivities), medical factors (e.g. dementia, heart disease), developmental level, neurological or genetic factors (e.g. Traumatic Brain Injury, Prader-Willi Syndrome), and psychiatric disorders (e.g. mood disorders, anxiety disorders).

Additionally, any traumas an individual has experienced should be included in the FBA and considered when recommending support strategies. Even if serious traumatic events, referred to in the trauma-informed care literature as "big T" traumas, are not identified in the individual's life, thought should be given to the likely "little t" traumas, or events experienced as traumatic at a personal level, that have occurred in the person's life. Moreover, past incidents of restraint and psychiatric hospitalizations should be recognized as potentially traumatic experiences. Sensitivity to an individual's culture and native language are also expected to be demonstrated in the conduct of the FBA and development of the IBSP.

Information gathered through the FBA process should lead to the development of the IBSP, especially hypotheses regarding the functions of the targeted behaviors. All services and supports provided and described in the IBSP should create an enriched, safe, supportive and healing environment where the individual has choices in matters affecting his/her everyday life. They should emphasize learning and teaching alternative behavior within a positive framework rather than relying on negative or punitive consequences to stop behaviors that are undesirable or dangerous.

IBSPs are to include both proactive and reactive strategies. Proactive strategies focus on future reductions in the occurrence of target behaviors, increases in skill development, and improvement in a person's quality of life, including the reduced use of restrictive procedures such as restraint. Proactive interventions include, but are not limited to: environmental changes that create better matches for the person; teaching general, functionally-equivalent, functionally-related, and coping and tolerance skills; preventative/antecedent strategies; and consequence strategies such as certain schedules of reinforcement.

Reactive strategies focus on rapid and safe management of a behavioral crisis. A continuum of emergency strategies should be individualized with an emphasis on less restrictive, non-physical strategies including, but not limited to: redirection; active listening, stimulus change, redirection to a preferred activity, withdrawing a demand, strategic capitulation, inter-positioning, and using cushions or pads. If less restrictive strategies are ineffective, more restrictive strategies, such as restraint, are only to be used in accordance with the facility's approved emergency intervention plan and with relevant laws and regulations.

Delayed Egress and Secured Perimeter

If the EBSH has a delayed egress with or without a secured perimeter, the FBA and IBSP should directly address how the person is being supported and taught skills and replacement behaviors to ultimately live in the least restrictive setting possible. It is important to note that the EBSH model affords individuals the opportunity to live in a less restrictive environment without having to move. For example, as a person develops safety awareness and coping and tolerance skills, the door alarm or delayed egress may be turned off or the person may learn how to use the code independently, or there may be a decrease in the intensity of staff support. All staff must be trained in individual rights with regard to the delayed egress system and must understand that individuals retain the personal right to come and go from their home.

Individual Behavior Supports Teams

Individual Behavior Supports Teams
• Develops, monitors, and revises the IBSP • Includes, at minimum, the individual, administrator, QBMP with the authorized representative, regional center representative, and clients' rights advocate, unless the individual objects on his or her own behalf to their participation • Meets at least monthly to review the IBSP

WIC §4684.80(d), Health and Safety Code §1567.61(c), and Title 17 §59050(s) define the IBST as those individuals who develop, monitor, and revise the IBSP for individuals living in EBSHs. These teams are

required to, at a minimum, include: the individual and his or her authorized representative, as appropriate; the regional center service coordinator or other regional center representatives, as necessary; the EBSH's administrator and QBMP, the regional center clients' rights advocate unless the individual objects on his or her own behalf to their participation; and others deemed necessary by the individual, and his or her authorized representative, for developing a comprehensive and effective IBSP.

As noted above, the IBST includes the regional center clients' rights advocate. EBSH providers need to contact the Office of Clients' Rights Advocacy (OCRA, a part of Disability Rights California) to identify the Clients Rights' Advocate(s) assigned to their geographic area so they know who to invite to IBST meetings and where to send updated IBSPs as required in statute and regulation.

The goal of a person's support team is presumably to help the person have as much positive control as is possible in his/her life. The role of the IBST is to find the best balance between what the person wants, what others want for the person, and issues of health and safety. Within a person-centered framework, the individual, with the support from required IBST members, should identify other individuals (e.g., family, friends, direct support staff from day and/or residential services) who can make significant contributions to the planning process and include them on the IBST on a situational or regular basis.

Input from the IBST must be sought when developing the initial IBSP, as well as when conducting the FBA. Title 17 §59054(c) also notes that the IBST is required to review the IBSP monthly and provide updated information as necessary. The EBSH administrator must determine the structure of these monthly reviews and ensure that all IBST members, including the CRA, are given the opportunity to provide input.

The team may also be called together immediately after a significant event has occurred. For example, if law enforcement was involved in response to a crisis, the team may want to meet. Also, if physical restraint was used to safely resolve a dangerous situation, it is recommended that IBST members be added as participants in the debriefing process.

An effective person-centered thinking tool that can be used during monthly IBSP reviews and other IBST meetings, is the "4 plus 1 questions": *What have we tried? What have we learned? What are we pleased about? What are we concerned about?* These are useful questions in gathering the support team's learning about how the individual is doing since the team's last meeting. This is a particularly helpful process because the group can learn from each other's different perspectives. It is also a quick way to identify better ways of supporting the person and working together to answer the fifth ("plus 1") question – *Based on what we know, what do we do next?* – which results in updating the IBSP, as needed. Using this process, flip chart paper can be put on the wall, or regular sheets of paper can be placed on a table, with each question written on the top. As IBST members arrive for the meeting, they can write on the paper and during the meeting, the information gathered can be reviewed and discussed to inform the answer to the fifth question.

Emergency Intervention Plans

The best crisis is the one that doesn't occur at all. To the extent that support staff can meet the immediate and long-term needs of the individuals they serve and show dignity and respect toward them, the greater the probability of avoiding a crisis. However, staff must be prepared should a behavioral

crisis occur. EBSH providers are required to develop both facility and individual emergency intervention plans as per Title 22 §85322, §89901(a)(3) and §85301(i)(2).

As defined by Title 17 §59050(l)-(m) and Title 22 §85301, emergency interventions are those used during a time when an individual presents an imminent danger to self or others and only when less restrictive techniques have been used without success. They are safety measures meant to prevent impending risk of serious harm by offering immediate and short-term support to an individual who is experiencing an event that has the potential of resulting in injury to self or others. The emergency intervention plan is a written plan, addressing the implementation of emergency procedures and prevention of injury.

The regulations that guide the use of restraint in EBSHs, as well as in other community care facilities and group homes for individuals with developmental disabilities, focus heavily on the definition of restraint and parameters of its use. The regulations also state that more restrictive interventions can only be used after less restrictive strategies have been determined to be ineffective (Title 22 §85300(b)). These Guidelines provide supplemental information about a continuum of emergency interventions/reactive strategies and methods for measuring their effectiveness to assist EBSH providers in developing both their facility Emergency Intervention Plans (EIPs) and Individual Emergency Intervention Plans (IEIPs) for the individuals they serve.

Facility Plans

As per Title 22 §85322(a), an EIP has to be developed and approved by the Department prior to the use of restraint or if it is reasonably foreseeable that staff will use this technique. The EIP must be designed and approved by the EBSH applicant or licensee in conjunction with a Behavior Management Consultant and must be part of the EBSH Plan of Operation (Title 22 §85322(a)(1)).

Title 22 §85322(b)-(c) also requires the EIP to specify the least restrictive or non-physical de-escalation methods that may be used to identify and prevent behaviors that could lead to the use of restraint. It must also specify those strategies that might be used in an emergency when the use of restraint is necessary to prevent serious physical harm to an individual and no lesser restrictive or non-physical technique has been effective in doing so. Similarly, Title 22 §85300(b) requires the use of a continuum of interventions starting with the least restrictive and only when those less restrictive interventions have proven ineffective, can a more restrictive intervention, such as restraint, be used when an individual's behavior presents an imminent danger of serious injury to self or others.

It is important to note that while Title 22 §85322(a)-(d) refers to both restraint and seclusion as last resort strategies to prevent serious physical harm; seclusion is never to be used in an EBSH (Title 17 §59051(f)). This is also consistent with Title 17 §50515(a), stating that no individuals with developmental disabilities in community care facilities or group homes shall be placed in seclusion. As such, these Guidelines refer only to restraint when describing required components of EIPs.
EIPs are required to include, but are not limited to, the following items from Title 22 §85322(d):

- staff qualifications sufficient to implement the EIP;
- a list of the staff required to be trained to use restraint (by job title);
- a list of emergency interventions beginning with the least restrictive one, that includes a description of each of the interventions that may be used;

- a statement that if prone containment is included as a potential emergency intervention in the EIP, it must only be used in compliance with Health and Safety Code §1180.4(f);
- a description of the circumstances and the types of behaviors for which the use of emergency interventions may be needed;
- procedures for maintaining care and supervision and reducing the trauma of other individuals with disabilities in the area when staff are required to use emergency interventions simultaneously;
- procedures for crisis situations, when more than one individual requires the use of emergency interventions simultaneously; and
- procedures for re-integrating the individual into their daily routine after the need for an emergency intervention has ceased.

Title 22 §85300(b) aligns with the above requirement to use a continuum of interventions, starting with the least restrictive intervention and requires that more restrictive interventions only be used when less restrictive interventions have been determined to be ineffective.

Additionally, Title 22 §85322(f)(1)-(6) requires that the EIP include an emergency intervention training plan and outlines the required components of the plan, to include:

(1) The course type, title and a brief description of the training staff completed;
(2) Training requirements for new staff;
(3) The ongoing training requirement for existing staff including timeframes and frequency of refresher training to ensure staff maintain their skills;
(4) Training curriculum;
(5) The qualifications of the instructor(s) providing the training;
(6) Evidence that the training plan is based on research and that the training topics are appropriate for the targeted population and services provided by the facility.

More information about emergency intervention training can be found in the Staff Training section below. Specifically, recommendations are made in that section about selecting a professionally recognized crisis management training curriculum.

The EIP must also include procedures for debriefing each time after restraint is used (guidelines for debriefing are discussed in the Restraint and Containment section).

While proactive strategies focus on reducing the frequency, duration and intensity of a target behavior over time, reactive strategies focus on rapidly de-escalating a crisis by reducing the severity of a specific episode, or behavioral occurrence. When developing EIPs, EBSH providers must identify a continuum of emergency interventions/reactive strategies that prevent injury to, and maintain safety for, individuals who are a danger to themselves or others and must emphasize positive behavior supports and techniques that are alternatives to physical restraint (Health and Safety Code §1567.64).

Much conceptual and applied work in the area of emergency management and the use of less restrictive, nonphysical reactive strategies has been published by LaVigna and Willis (2002, 2004, 2005, 2005a, 2012, 2016, 2016a). As guest editors for a special issue of the *International Journal of Positive Behavioural Support* that focused on reactive strategies for situational management (LaVigna & Willis, 2016), they recommended clearly defining "first resort" or less restrictive, non-physical, reactive

strategies. This recommendation aligns with the regulatory requirement to include a list and description of emergency intervention strategies, beginning with the least restrictive, in the EIP.
When developing the list and description of emergency interventions/reactive strategies for inclusion in the facility EIP, the EBSH provider and Behavior Management Consultant/QBMP is expected to include an array of potential strategies, least to most restrictive, that staff can use to prevent and de-escalate crisis situations. Descriptions should be described in terms that are easily understood by lead and direct care staff, but also detailed enough to ensure that staff are trained and practiced in using them with competence and fidelity.

The following is a sample of less restrictive, non-physical reactive strategies gathered from a few resources (LaVigna & Willis, 2004; Service Alternatives, Inc., 2012). As this is not an inclusive list, EBSH providers are encouraged to include these, as well as other strategies they are familiar with through their own research and practice, in their program designs.

Reactive Strategies	**Definitions**
Active listening	nondirective, nonjudgmental communication reflecting back the message the person is sending
Relocating people	if the presence of a particular staff person or peer has a high likelihood of escalating the situation further, have that person move or disengage from the interaction
Removing unnecessary demands/requests	avoiding additional prompts or demands to allow person time to focus on using coping strategies
Changing proximity	move away from or closer to the person at strategic times
Providing strategic instruction	for individuals' who are compulsive about following directions, either generally or specifically, asking them to do something when they start escalating can divert them.
Facilitating relaxation	provide instructions to promote relaxation and calm based on the coping skills the person has been learning proactively
Redirecting	to a preferred item or activity or quiet location
Stimulus change	introduce an unexpected and sudden change in the environment to break the escalation cycle
Chain interruption	divert the person to a powerfully preferred or compelling event or activity
Strategic capitulation	giving in to the communicative message of the person's behavioral incident, e.g., withdrawing demands, giving the person what they are requesting
Inter-positioning	use of the immediate environment to minimize or eliminate potential injury or damage to self or others
Blocking	physically blocking aggressive behavior taught in certified self-defense program with arm or protective padding or household items (e.g. pillows)
Escorting	walking or staying with consumer without physically guiding them to continue engagement and supports

Providers are prohibited from using punitive strategies in reaction to crisis situations as one of the potential side effects of punishment is an increase in aggression. This is in direct conflict with the goal

of a reactive strategy, which is to resolve a crisis situation as quickly and safely as possible. Concerns about "accidentally reinforcing" target behaviors by using reactive strategies that withdraw requests or "give in" to the communicated message of the person in crisis are understandable. Though such strategies may seem counterintuitive, the risk of reinforcing target behaviors are minimized or avoided within a positive behavior supports framework because proactive strategies enrich the individual's environment and provide a rich schedule of reinforcement for alternative non-challenging behaviors (Crates & Spicer, 2016; LaVigna & Willis, 2004).

When developing the facility's EIP, EBSH providers are strongly encouraged to evaluate their own and/or their staffs' resistance to using potentially effective strategies because they don't want to "give in" and lose a perceived power struggle. It is critical that all staff supporting individuals with challenging behaviors have well-developed self-regulation skills to ensure that the desire to "win" a power struggle does not preclude the use of strategies that safely and rapidly end crisis situations without the use of restraint (Crates & Spicer, 2016; LaVigna & Willis, 2012). There must be a "shift in mindset from the goal of winning the power struggle to the goal of serving the person's need" (http://rightresponse.org/training-workshop/physical_intervention).

Individual Emergency Intervention Plans

In addition to the facility EIP, EBSH providers must develop IEIPs for the individuals they serve based on the initial assessment done prior to placement in the EBSH (Title 22 §89968.2(a)(1) and §85068.2(b)(1)(G)). A separate IEIP document is not required if the IBSP addresses all the provisions of the IEIP (Title 17 §59054). The Department recommends one unifying document for ease of training staff and ensuring consistent implementation of all proactive and reactive strategies, including emergency interventions.

Title 22 §89901(a)(3) and §85301(i)(2) defines an IEIP as "a written plan addressing the prevention of injury and implementation of emergency intervention techniques by the licensee that will be used with a specific client, which are in addition to and are not prohibited by, the emergency intervention techniques set forth in the facility Emergency Intervention Plan. The plan shall be developed in consultation with a Qualified Behavior Modification Professional with input from the client and if available, someone whom he or she desires to provide input in accordance with Health and Safety Code §1180.4(a). The plan shall include client-centered problem solving strategies that diffuse and safely resolve emerging crisis situations and strategies to minimize time spent in seclusion or behavioral restraints."

As per Health and Safety Code §1180.4(a)(1)-(5), the initial assessment is required to include the following items based on information available at the time it is conducted:

(1) A person's advanced directive regarding de-escalation or the use of seclusion or behavioral restraints.
(2) Identification of early warning signs, triggers, and precipitants that cause a person to escalate, and identification of the earliest precipitant of aggression for persons with a known or suspected history of aggressiveness, or persons who are currently aggressive.
(3) Techniques, methods, or tools that would help the person control his or her behavior.
(4) Preexisting medical conditions or any physical disabilities or limitations that would place the person at greater risk during restraint or seclusion.

(5) Any trauma history, including any history of sexual or physical abuse that the affected person feels is relevant.

Seclusion is prohibited in EBSHs, even though it is included in the above Health and Safety Code reference (Title 17 §59051(f)).

While the facility EIP provides a toolbox of emergency interventions/reactive strategies that staff may use to help someone de-escalate, one size does not fit all. The reactive strategies that have the highest probability of gaining safe and rapid control of a behavioral incident for one person may be ineffective or even escalate the situation with someone else. Therefore, an individualized continuum of emergency interventions/reactive strategies must be identified through the initial assessment process done prior to the person's placement in an EBSH, through the FBA process and in the development of the IBSP. In addition to gathering information about an individual's medical conditions, physical limitations and trauma history, psychological and medical contraindications to particular emergency interventions, including restraint, must also be included in the IEIP. Identifying signs specific to the individual that indicate when imminent risk no longer exists must also be included so that more restrictive strategies are discontinued as soon as safely possible.

As per Title 22 § 85368.2(a)(1)-(3), an IEIP must be developed if restraint is reasonably expected to be used due to an individual's potential to engage in behavior that results in an imminent danger to self or others. The IEIP must be updated as needed to ensure it meets the safety needs of the individual. Additionally, the individual or his/her authorized representative, if any, must receive a copy of and approve the IEIP and any revisions to the plan prior to implementation.

The IEIP can be useful in managing a crisis situation and in reducing or avoiding the use of restraint for an individual. However, there are differing views among professionals about whether restraint should be included in the IEIP as a potential emergency intervention. Some view the inclusion of restraint in the IEIP as approval of its use; potentially increasing the probability of its use. Others view the inclusion of restraint in the IEIP as a safeguard for ensuring full knowledge of the individual's unique circumstances and needs, thusly minimizing risk of injury and length of time in restraint, should it be needed as a last resort intervention. Based on the regulations defining the purpose and components of the IEIP, if restraint is reasonably expected to be used due to an individual's potential of engaging in behavior that results in an imminent danger to self or others, the Department expects a description of how and when the restraint will be used and strategies to reduce the duration of the restraint to be included in the IEIP.

Development of the IEIP is meant to be a collaborative effort that includes the individual. It is intended to help the individual maintain or regain control of his/her emotions and actions at the earliest signs of distress to avert a crisis. It also intends to ensure that staff know what to do to support an individual if a problem arises and that they use strategies that minimize risk and trauma. If there is any possibility that restraint may be needed in response to a crisis situation, the individual and his/her authorized representative, if any, should have the opportunity to share preferences and recommendations for inclusion in the IEIP. Given that individuals, and their authorized representatives, if any, must receive a copy of and approve the IEIP, inclusion of restraint as a last resort emergency intervention is also seen as an important safeguard if there is any possibility of its use.

When IEIPs include restraint as a last resort emergency intervention, EBSH providers must ensure that staff do not view it as approval or acceptance of its use, but rather as a safeguard for ensuring that the unique safety needs of the individual are met in a crisis. EBSH providers are responsible for creating a culture that ensures a positive therapeutic environment and reduces or eliminates the use of restraint.

To foster such a culture, EBSH providers should focus on figuring out what went wrong during incidents where restraint was used. What was missed? What wasn't understood about the needs of the individual? This is not done to be punitive, but rather to evaluate the circumstances in a way that upholds dignity and respect for the individual, works to repair the relationships that may have been impacted by the restraint event, and identifies different actions that can be taken to avoid the use of restraint in the future.

Moreover, EBSH providers must assess and monitor the use of restraint and ensure that it is only used as a last resort measure. EBSH providers also must evaluate the fidelity in which less restrictive, non-physical reactive strategies are used and their effectiveness in safely and quickly decreasing the severity of a specific incident. This evaluation will inform the development and/or revision of the IBSP and/or IEIP to ensure that the most effective and least restrictive strategies are used to avoid or quickly de-escalate an imminent crisis.

Restraint and Containment

EBSH providers have a responsibility to ensure that staff are prepared to identify an individual's triggers and early warning signs and to respond effectively to prevent or resolve conflict. When services and supports are person-centered and strive to minimize conflict and other triggers, the use of restraint can be reduced or avoided. That said, it is important to recognize that EBSH providers support individuals with complex needs and some trigger events may not always be prevented. In circumstances when restraint is used, it is the EBSH provider's responsibility to ensure that restraint is not misused or abused.

Each time restraint is used, it should be recognized as potential trauma to the individual. Its use can affect an individual's relationships with support staff and have short- or long-term effects on the person's mental health. For example, it can generate shame, embarrassment and fear that can linger long after restraint has ended. Restraint is not a treatment or a substitute for treatment. Restraint use for punitive purposes, discipline, staff convenience, retaliation or coercion is considered abuse. As such, there are numerous laws and regulations related to the use of restraint with individuals with developmental disabilities. Restraint is always a last resort safety measure when there is an imminent threat to the health and/or safety of the individual or others and only when less restrictive methods have been ineffective in resolving a crisis situation safely and rapidly.

The Association for Behavior Analysis International (ABAI) published a position statement on restraint and seclusion (Vollmer, et al., 2011), which includes a discussion on the use of emergency restraint as well as on the oversight and monitoring of restraint. Reference to ABAI's position in these Guidelines is specific to their position on the use of emergency restraint. It should also be noted that ABAI's position statement refers to the use of seclusion in addition to restraint; however, Title 17 §59051(f) clearly states that EBSHs shall not utilize seclusion, which is also consistent with Title 17 §50515(a) stating that no person with a developmental disability shall be placed in seclusion. The following is an

excerpt from ABAI's position statement (Vollmer, et al., 2011) that aligns well with California laws and regulations and supports the recommendations made in these Guidelines.

> *"The Necessity for the Use of Emergency Restraint and Seclusion*
>
> *…When applied for crisis management, restraint or seclusion should be implemented according to well-defined, predetermined criteria; include the use of de-escalation techniques designed to reduce the target behavior without the need for physical intervention; be applied only at the minimum level of physical restrictiveness necessary to safely contain the crisis behavior and prevent injury; and be withdrawn according to precise and mandatory release criteria.*
>
> *Emergency restraint procedures should be limited to those included in a standardized program. Medical professionals should review restraint procedures to ensure their safety.*
>
> *Consideration of emergency restraint should involve weighing the relative benefits and limitations of using these procedures against the risks associated with not using them. Associated risks of failure to use appropriate restraint when necessary include risk of injury; excessive use of medication; expulsion from school; placement in more restrictive, less normalized settings; and increased involvement of law enforcement…*
>
> *Oversights and Monitoring*
>
> *Restraint….situations should be made available for professional review consistent with prevailing practices.*
>
> *…These procedures should be implemented only by staff who are fully trained in their use, receive regular in-service training, demonstrate competency using objective measures of performance, and are closely supervised by a Board Certified Behavior Analyst or a similarly trained professional…*
>
> *…With respect to emergency treatment, efficacy refers only to the time and risk associated with achieving calm."*
>
> *(Vollmer, et al., 2011, p.106, 107)*

Summary of Laws and Regulations

A multitude of laws and regulations exist with regard to use of physical restraint or containment. Many of the regulations referenced here address both the use of physical restraint and seclusion. However, Title 17 §59051(f) clearly states that EBSHs shall not utilize seclusion, which is also consistent with Title 17 §50515(a) stating that no person with a developmental disability shall be placed in seclusion.

Throughout this document, the term "restraint" is used to mean physical restraint. Within Title 17 and Title 22 regulations, as well as in Health and Safety Code, the terms "manual restraint" and "behavioral restraint" are used synonymously (e.g., Title 22 §85301(m)(1), Health and Safety Code §1180.1).

Definitions of Containment and Restraint

Although defined somewhat differently across regulations, the two critical features across all regulations is that (1) restraint or containment limits a person's voluntary movement and (2) restraint is solely used for the purpose of keeping the person from causing serious harm to self or others. Some definitions differentiate between restraint and the physical contact staff may have with individuals to calm or

comfort them, to assist them in performing tasks or guiding them from one place to another. All support staff should have knowledge of the following definitions.

Containment is defined in Health and Safety Code §1180.1(b) and Title 22 §85301(c)(3) as "a brief physical (manual) restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others."

In Title 22 §85301(m)(1), manual restraint is synonymous with physical restraint and is defined as "the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint on a client who presents an imminent danger to his or her self or to others. Techniques include, but are not limited to, forced escorts; holding; wall restraint; brief prone containment; or any staff-to-person physical contact in which the person unwillingly participates."

Physical restraint is similarly defined by Health and Safety Code §1180.1(d) as "the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint." It is also described as any "staff-to-person physical contact in which the person unwillingly participates." The definition of physical restraint "does not include briefly holding a person without undue force in order to calm or comfort, or physical contact intended to gently assist a person in performing tasks or to guide or assist a person from one area to another." (Health and Safety Code §1180.1(d))

Restraint, as per Title 17 §50501(16) is defined as "control of the client's behavior or activities through the use of physical or pharmaceutical means other than postural support" and is "distinguished from the temporary constraint of a client by direct physical contact only, where there is clear evidence for believing the existence of an imminent danger to either the client or others if such constraint is not accomplished."

The Use of Restraint as a Last Resort

Restraint may be used as a last resort emergency intervention in limited, unforeseen circumstances for the purpose of protecting the safety of an individual or others. Restraint may only be used by support staff who are trained in the proper use of restraint. There must be a real possibility of serious physical harm or death to someone's life, health or safety if no action is taken. There also must be documented evidence that less restrictive, nonphysical strategies were attempted first and without success.

Restraint should only be used when it will make the situation safer. The use of restraint is inherently risky and is associated with risk of injury and potential trauma to both the individual and to the staff who use it. It can also escalate rather than de-escalate the immediate situation and create a more unsafe situation. As such, staff must be trained to weigh the risks in the moment. Is the person's behavior more dangerous than the danger of using restraint? Will a physical response reduce the imminent danger or will it increase the risk of harm? If staff have to use restraint, it must be done in accordance with all laws and regulations and in compliance with an authorized training program and the facility and individual EIP.

Restraint is never to be used for the purpose of controlling or managing behavior (i.e., as a proactive consequence strategy). Nor should it be used for compliance, punishment or retaliation. Restraint must only be used as a last resort measure for the purpose of protecting the safety of the individual and others. The goal is not to win a power struggle. The goal is to maintain safety in a way that serves the person's needs and shows respect and dignity to the person. To that end, every effort should also be made to protect the individual's privacy and not restrain him/her in public view.

During the use of restraint, a trained staff not involved in the restraint should be constantly assessing and monitoring the individual's physical and psychological status to ensure health and safety as outlined in Title 22 §85322(e)(5)(A)-(F). The assigned staff must be able to visually observe the individual at all times and should be able to hear and be heard by the individual. The staff should also assess the situation to ensure the safety of the staff involved and to ensure that they are maintaining control of their emotions and actions. If there is an issue with a staff member losing emotional or physical control, the monitoring staff should take immediate steps to have that person replaced or directed to regain composure. This staff is also monitoring the situation to determine when imminent danger no longer exists so that restraint can be discontinued as soon as possible and/or to determine whether community emergency services need to be called.

Prohibited Emergency Interventions

Title 22 §85302(a)(1)-(15) lists emergency interventions that are prohibited in all community care facilities, including EBSHs. Those prohibitions include the use of:

- Mechanical restraint;
- Restraint as an extended procedure;
- Restraint when imminent risk is no longer present;
- Emergency interventions that rely on punishment, discipline, harassment, humiliation, coercion, retaliation, verbal abuse or physical threats for control;
- Emergency interventions that rely on pain for control;
- Restraint that restricts breathing;
- Restraint that holds a person's hands behind the back;
- Restraint in which a staff member places pressure on a person's back or places his/her body weight against the person's torso or back;
- Placement of an item that covers a person's head or face (padding under the head to prevent injury is permitted if it does not impair breathing);
- The use of behavior modifying drugs in a manner prohibited by Health and Safety Code §1180.4(k);
- Emergency interventions, including restraint, that are medically contraindicated;
- Isolation in an area from which a person cannot leave voluntarily;
- Restraint lasting for more than 15 consecutive minutes unless in compliance with Title 22 §85322(e)(6).

Furthermore, as specified by Title 22 §85302(b)(1)-(7), restraint is never to be used as a substitute for staff or for the convenience of staff. Nor is it a substitute for a treatment or behavior support plan. It should not be used to prevent an individual from leaving a room or area of the home when no immediate threat exists to the health and safety of the individual or others. Restraint is never to be used when an

individual has a medical or physical condition that could endanger the individual's life or when it could worsen the medical condition. Nor can it be used if it is prohibited in the facility EIP or the IEIP.

Concerns about Prone Containment

As per Health and Safety Code §1180.4(f), community care facilities, including EBSHs, must "avoid the deliberate use of prone containment techniques whenever possible, utilizing the best practices in early intervention techniques, such as de-escalation. If prone containment techniques are used in an emergency situation, a staff member shall observe the person for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the person shall not be involved in restraining the person." Of note, Title 22 §85322(e)(5) requires monitoring to be done by a trained staff who is not involved in the restraining the person without exception, not "whenever possible". The Department also strongly advises against prone containment procedures that includes staff physically forcing an individual from a standing position to a prone containment position due to the risks of injury to the individual and staff.

Alternative restraint positions to prone containment are strongly advised. EBSH providers should take this into account when selecting a professionally recognized emergency intervention training program to ensure that staff are trained in using alternative positions. However, that does not suggest that other restraint positions are completely safe. No type of restraint is completely safe. EBSH providers and staff must understand that restraint-related deaths and injuries have occurred in other restraint positions, not just in prone position. The critical concern is the potential of compromised breathing and the potential risk factors that may increase the likelihood of injury to an individual as a result of being restrained.

Time Limits on the Use of Restraint

When restraint is used, it needs to be kept at an absolute minimum in terms of frequency and should be used with the minimum force necessary for the shortest period of time. It should only be used while an unsafe situation continues and imminent danger remains. The use of restraint must be discontinued as soon as the unsafe situation ends.

Title 17 §50515(b)(2), for example, states that restraint must not continue longer than necessary to control the behavior for which the restraint was employed. EBSHs, specifically, must ensure that physical restraint is not used as an extended procedure (WIC §4684.81(i)(3). Title 22 §85302(a)(14), and Health and Safety Code §1180.4(h), state that physical restraint is not to be used for more than 15 consecutive minutes.

The only exception to the 15-minute limitation is described in Title 22 §85322(e)(6)(A), which allows for restraint to continue only when there is a continued need to protect the immediate health and safety of the individual or others from imminent danger and there is concurrent approval obtained by the EBSH administrator for every exception. In such cases, the administrator is not to be a participant in the manual restraint. Extreme caution and diligent monitoring are especially critical during episodes in which restraint lasts more than 15 minutes to ensure the health and safety of the individual and the staff.

The facility EIP must outline procedures to ensure the safety of individuals and staff in the event that an exception to the 15-minute limit must be made. This includes required documentation in the individual's record of administrator approval within 24 hours, an explanation of why it was necessary for restraint to go beyond 15 minutes and a detailed description of the individual's imminently dangerous behavior.

By regulation, restraint cannot continue after 15 minutes if an exception has not been authorized and/or individual safeguards are not outlined in the facility EIP. If imminent risk continues upon release from the restraint after the 15-minute period ends, it may need to be implemented again to maintain safety if less restrictive emergency interventions are utilized without success.

Assessment of Potential Physical Injury after Each Use of Restraint

Immediately after each use of restraint, the individual's immediate needs should be assessed by the EBSH administrator or administrator's designee. This must be an in-person communication with the individual to assess physical well-being. Title 22 §85369(a)-(b) specifically requires an assessment to determine whether there is physical injury or suspected physical injury and whether a medical examination is needed by a qualified medical professional. If medical attention is sought, it must be documented in the individual's record. If suspected physical injury or a complaint of physical injury to the individual are reported to or witnessed by staff during or after the restraint, it must be reported to the administrator or administrator's designee immediately. In this case, a written incident report must be submitted to the Department of Social Services (Title 22 §85361(b)) and the regional center (Title 17 §54327). Suspected serious injury is also to be reported immediately to a qualified medical professional for examination.

The individual's psychological well-being should also be immediately assessed and steps should be taken to determine the need for emotional support and treatment of trauma for the individual. EBSH providers are also encouraged to immediately assess the physical and psychological well-being of the staff involved in the restraint as well as of anyone who observed the restraint and provide support as needed.

Debriefing After the Use of Restraint

EBSH providers must ensure that a post-event analysis, including debriefing activities, occurs after every incident involving the use of restraint. A formal debriefing should take place to determine what led to the incident, what might have prevented or shortened the incident, and what can be done to prevent future incidents. Both Health and Safety Code §11809.5(a)-(d) and Title 22 §85368.3 and Health and Safety Code §1180.5 describe the debriefing process that must occur after each episode of the use of restraint.

EBSHs are required to conduct a clinical and quality review for each episode of the use of restraint as quickly as possible, but no more than 24 hours after the incident. Attendees of the debriefing should include, at minimum, the individual who was restrained and as requested, the individual's significant others (e.g., family) or authorized representative, as well as the staff involved in the incident and a supervisor if they can be present at the time of the debriefing and at no cost to the facility. The individual's participation in the debriefing is voluntary and EBSH providers are encouraged to actively

engage and support the individual in the process. The QBMP plays a critical role in ensuring that the IBSP and IEIP are effectively serving the individual, so should also be in attendance.

Debriefing activities include:

- Identifying what lead to the incident and what factors contributed to it leading to the use of restraint.
- Assessing alternative methods of responding to the incident that may have avoided the use of restraint.
- Evaluating whether staff used emergency interventions consistent with the facility EIP, the IBSP and IEIP, and with staff training.
- Evaluating whether the individual was in restraint for the least amount of time necessary.
- Evaluating the effectiveness of less restrictive de-escalation strategies that were attempted to ensure that they were implemented with fidelity and if they were not effective or were counterproductive, that they are discontinued.
- Determining whether the individual's physical and psychological well-being and right to privacy were addressed appropriately.
- Considering treatment for any trauma that may have been experienced for the individual and staff as a result of the incident.
- Identifying alternative ways of helping the individual avoid or cope with difficult situations such as those that led to the use of restraint.
- Identifying the need to do a new FBA, revise or refine the IBSP and IEIP, retrain staff and/or investigate medical variables.

Documentation of the debriefing meeting must include findings of the review, any revisions needed to the IBSP and IEIP to better serve the individual, and any refusal by the individual to participate in the review.

If the individual refused to participate in the debriefing, EBSH providers are encouraged to seek input from the individual in other ways that ensure dignity and respect. Consideration should be given to finding alternative ways to debrief with the individual to ensure that relationships are reestablished and the person feels safe. Whether during the formal debrief meeting or at another time after the episode of restraint, questions that might be asked of the individual are as follows:

- How can we better understand what you needed at that time?
- How can we better understand what you need to deal with challenging situations?
- What upset you most about the situation?
- What did we do that helped you?
- What did we do that didn't help you or got in the way of helping you?
- What can we do better or differently to support you next time?
- Is there anything you would do differently?

Responses to these and other questions, even if gathered separate from the formal debriefing meeting, should be used to determine if revisions are needed to the IBSP and IEIP or if additional staff training is needed. These responses should also be documented in the individual's record and could be included as an addendum to the debriefing meeting minutes.

In addition to a review of each incident of restraint, if emergency restraint used on more than three occasions within a three-month period and/or the recurrence of the dangerous behavior can be anticipated, the Department strongly recommends that the person and the IBST meet. The person's IBSP, the person's ongoing support needs, and alternatives to restraint should be reviewed. In addition to IBST members, other key individuals should be invited to attend the meeting as appropriate.

Staff Training

Service providers consistently share that the key to their success in providing quality services to individuals with developmental disabilities is through the recruitment, training and retention of quality staff. This is especially true when the individuals served by the provider have intensive needs, such as those living in EBSHs.

EBSH Staff Qualifications

The table below shows the staffing requirements for EBSHs as per Title 17 §59060, §59061 and§59050.

Qualifications	Administrator	Lead	Direct Support Professional (DSP)	Qualified Behavior Modification Professional (QMBP)
Experience	Minimum two years' prior experience with individuals with developmental disabilities	Minimum one year prior experience with individuals with developmental disabilities with a focus on behavioral services	Six months' prior experience with individuals with developmental disabilities with a focus on behavioral services	Minimum two years' prior experience in designing, supervising and implementing behavior modification services
Credentials	Must be: (A) A registered behavior technician (RBT) OR (B) A licensed psychiatric technician (LPT) OR (C) A qualified behavior modification professional	Must become a RBT within 60 days of initial employment; or be either (A) A LPT OR (B) A qualified behavior modification professional	Must become a RBT within 12 months of initial employment; or be either (A) A LPT OR (B) A qualified behavior modification professional	Must be: (1) An Assistance Board Certified Behavior Analyst (BCaBA) OR (2) A Board Certified Behavior Analyst (BCBA) OR (3) A Licensed Clinical Social Worker (LCSW) OR (4) A Licensed Marriage and Family Therapist (LMFT) OR (5) A psychologist, licensed by the California Board of Psychology OR

Qualifications	Administrator	Lead	Direct Support Professional (DSP)	Qualified Behavior Modification Professional (QMBP)
				(6) A professional with California licensure, which permits the design of behavior modification intervention services.

Selection of Qualified Behavior Modification Professionals

In addition to ensuring that EBSH providers recruit QBMPs who meet the minimum qualifications required by Title 17 as stated above, the Department also encourages a critical evaluation of additional knowledge, skills and abilities of potential candidates. To assist with that evaluation, the following checklist is offered as a starting point for vetting QBMP candidates.

Considerations when Recruiting Qualified Behavior Modification Professionals
Meets qualifications as required by Title 17 section 59050(v)
Experience working with adults with significant challenging behaviors (and/or with children if the EBSH provides services to children)
Experience training, coaching and mentoring DSPs
Embraces an approach that emphasizes positive behavior supports, person-centered practices and trauma-informed care in their practice
Utilizes best practices when conducting functional behavior assessments and developing individual behavior supports plans
Uses objectives to plan, implement and evaluate the effectiveness of the interventions recommends
Employs an array of empirically validated teaching strategies – modeling, incidental teaching, task analysis, chaining, activity-embedded instruction
Incorporates a variety of techniques to help with skill building – prompting, errorless teaching, maximizing learning opportunities, effective reinforcement, preference assessment and choice procedures
Employs a wide range of strategies for skill acquisition and skill generalization over time and across people, settings, situations, and activities
Knowledgeable about the laws and regulations regarding the provision of services in EBSHs and on the use of restraint

Another consideration when selecting a QBMP is whether or not the EBSH provider employs DSPs who will become RBTs and/or who will need to maintain their RBT certifications. The Behavior Analyst Certification Board outlines on its website (www.bacb.com/rbt/) the requirements for RBT certification (i.e., 40-hour training, competency assessment and exam), maintenance of the certification (i.e., ongoing supervision and annual competency assessment) and the required qualifications of those who can conduct competency assessments and provide ongoing supervision (i.e., a Board Certified Behavior Analyst – BCBA). If the QBMP is not a BCBA, the EBSH provider will need to engage a BCBA to meet the RBT requirements for initial certification and for maintenance of the certification.

Training Requirements for Direct Support Professionals

The Department believes that individuals with developmental disabilities are entitled to the highest standard of service and that direct support professionals deserve training and recognition as professionals. The table below shows the training requirements for all DSPs working in EBSHs, regardless of whether they are RBTs, LPTs or QBMPs.

Statute/Regulation	Training Requirement	Hours Required	By When
Title 17 §59063(a), Title 22 §80065(f), §84065(i)	On-site orientation	32 hours	Within first 40 hours of employment
Title 17 §59063(d)	Hands-on training in first aid and cardiopulmonary resuscitation	Not specified	Certification prior to providing direct care to individuals and maintained throughout employment
Title 17 §56033(b)-(g),(i)	Two segments of competency-based training* and passage of competency test OR Pass the challenge test	70 hours	Prior to or within one year of employment
WIC §4684.86(a)(1)(A), Title 17 §59063(b), Title 22 §85322(f), §85301(3), §85365, §89965(i), §89901(e)(3), Health & Safety Code §1567.64	Emergency intervention training	16 hours	Prior to implementing emergency intervention techniques
Title 22 §89965(m), §89965(h)	Continuing education	20 hours	Annually

*The Department has established a competency-based training program that is mandatory for all DSPs (and administrators who provide direct support) working in licensed community care facilities vendored by regional centers. The DSP Training is based upon core competencies or skills necessary for satisfactory job performance (http://www.dds.ca.gov/dspt/).

Emergency Intervention Training

As the focus of these Guidelines is on the use of restraint or containment, emergency intervention training is of particular importance. EBSH providers are required to have training in place that addresses how people are supported in emergency situations where an individual's health and safety may be at risk. As noted in the Emergency Intervention Plans section above, Title 22 §85322(f)(1)-(6) also requires that the EIP include an emergency intervention training plan.

In accordance with Title 22 § 89965(j), a DSP shall not implement emergency intervention techniques until they successfully complete the emergency intervention training. Title 22 §85365(c)-(d) delineates who can conduct emergency intervention staff training and what, at a minimum, must be included in the training curriculum.

Emergency intervention training must include a minimum of 16 hours of instruction to EBSH staff regarding techniques that may be used to prevent injury to, and maintain safety for, individuals who are a danger to themselves or others. The training curriculum must be evidence-based, emphasize positive behavior supports and include techniques that are alternatives to physical restraint. When an individual's behavior presents an imminent danger of serious injury to self or others, staff are required to use a continuum of strategies starting with the least restrictive strategy (Title 22 §85300(b)). Therefore, EBSH providers must ensure that DSPs receive competency-based training on less restrictive, non-physical reactive strategies aimed at rapid, safe situational management (such as those described above in the Emergency Intervention Plans, Facility Plans, section of this document).

The Department does not endorse any one curriculum. The following list is offered as a resource for EBSH providers who are searching for a professionally recognized crisis or emergency intervention program. Presented in alphabetical order, these are the organizations currently known to be used by providers throughout California. EBSH providers should also work with their vendoring regional centers to learn whether they know of other organizations or have specific recommendations.

- Crisis Prevention Institute (CPI), Inc. – www.crisisprevention.com
- Mandt System – www.mandtsystem.com
- Management of Aggressive Behavior (MOAB) – www.moabtraining.com
- Pro-Act, Inc. – Professional Assault Crisis Training – www.proacttraining.com
- Professional Crisis Management Association – www.pcma.com
- Quality Behavioral Solutions (QBS), Inc. – www.qbscompanies.com
- Therapeutic Options, Inc. – www.therops.com
- Ukeru Systems (Grafton Method) – https://www.ukerusystems.com/our-solutions/the-grafton-method/

The Department encourages EBSH providers to critically evaluate emergency intervention training programs before selecting the one they will use to meet staff training requirements. To assist with that evaluation, the following checklist is offered as a starting point for vetting emergency intervention training programs.

Considerations when Evaluating Emergency Intervention Training Programs
Instructor holds a valid certificate from a program for preventing and safely managing dangerous behavior
Professionally recognized organization
Purpose/mission aligns with purpose/mission of the EBSH provider
Evidence-based information about the broad range of variables that are important to preventing a behavioral crisis
Knowledgeable about the laws and regulations regarding the use of restraint in California and more specifically, in EBSHs.
Components included in curriculum

Considerations when Evaluating Emergency Intervention Training Programs
Positive behavior supports approach to prevention Trauma informed care Methods for assessing individual-specific information to ensure safety Crisis antecedents and de-escalation Non-physical intervention techniques Restraint procedures Restraint monitoring procedures Reintegration of individual back into routine after an crisis situation ends Procedures for documenting the use of restraint Debriefing and follow-up after restraint is used
Types of restraint included in curriculum Protection and releases Physical escorts Wall restraints Seated restraints Prone or supine floor restraints
Safety procedures included in curriculum Time limits on restraint More than one person involved in the restraint Monitoring the individual's physical state for symptoms of distress during restraint Monitoring the individual's emotional state during restraint
Types of instructional strategies incorporated within the training
Time allotment for each component of the training program
Training includes written and hands-on competency test
Training and certification/recertification requirements

Continuing Education for Direct Support Professionals

As per Title 22 §89965(m), in addition to any other required training, direct care staff shall complete a minimum of 20 hours of continuing education on an annual basis covering, at a minimum, the following subjects specified in §89965(h) – specialized needs of each individual, individual rights and protections, EBSH regulations, facility program plan, implementation of the individual's IPP, health and emergency procedures, including fire safety, and disaster and mass casualty plan.

The Department requires that EBSHs provide an additional 5 hours of competency-based continuing education in the areas of person-centered practices, positive behavior supports, trauma-informed care, and cultural competency. The Department also requires frequent refresher trainings on both facility EIPs and IEIPs, including role plays, return demonstrations, or hands-on practices to ensure ongoing DSP competence and confidence in dealing with crisis situations. DSPs need a high degree of readiness to implement every technique along the continuum so that at some point, they become "reflex actions". For example, monthly refreshers of 15 to 20 minutes could focus on one of the emergency strategies along the continuum. Refresher trainings could also be incorporated into the monthly IBSP review and focus on techniques that are most effective in avoiding or quickly resolving crisis situations for that particular individual. EBSH providers need to incorporate the details of these additional training hours into the facility program plan.

Data Collection, Monitoring and Reporting

Data Collection

EBSH program plans are required to include the methods they will use to measure an individual's progress (Title 17 §59052(a)(9)(A)). This includes the types of data to be collected, including data regarding the use of emergency interventions. EBSHs must maintain a facility file on site, which may be in an electronic format, and as related to these Guidelines, must include at least the EIP as well as data collection and reporting for target behaviors and emergency interventions (Title 17 §59070(d) and (h)).

Individual Behavior Supports Plans and Emergency Intervention Plans

Data should be collected regarding the effectiveness of both the proactive and reactive strategies included in the IBSP and IEIP. This includes collection of data regarding the frequency, duration and severity of targeted behaviors as well as skill development. Intensity of a targeted behavior is often measured on a scale of least to most harm or injury as a result of an occurrence of the target behavior.

It is standard practice to measure reductions in the frequency, duration and intensity of behaviors targeted in the IBSP to ensure that proactive strategies are contributing to desired outcomes (i.e., reductions in the target behaviors over time). Episodic severity, a measure of the intensity of a behavioral incident within the context of a behavioral cycle (LaVigna & Willis, 2005; Vollmer, et al., 2013), should also be included as a data collection method for evaluating an individual's progress. Analysis of data should include correlations with reductions or increases with setting events, such as medical issues, psychiatric conditions, changes to psychotropic medication, changes in routines, social or family relationships, and environment.

Reactive strategies are aimed at rapid, safe situational management so it is equally important to measure their effectiveness in resolving crisis situations. EBSH providers are obligated to protect the safety of the individuals they serve, and that of others, by using the least restrictive emergency strategies that effectively reduce the severity of, and quickly de-escalate, a behavioral crisis. The momentary effectiveness of a reactive strategy is measured, then, by determining if it results in de-escalating the crisis situation. If it escalates the situation, even momentarily, then it may be doing the opposite of what is sought from a reactive strategy (Spicer & Crates, 2016).

Restraint

Documentation of the use of restraint should include a description of the individual's behavior that required the use of restraint; the rationale for the use of restraint; what less restrictive, non-physical interventions were used and why more restrictive interventions were needed; and the individual's response to the use of restraint, including any injuries.

Title 22 §85361 (a)-(h) further details the documentation and reporting requirements regarding the use of restraint as an emergency intervention. EBSH providers must ensure compliance with these and other documentation and reporting requirements.

Monitoring

Quality of Functional Behavior Assessments

The following is an example of a brief checklist that might be created and utilized by Administrators to ensure that QBMPs are conducting FBAs that include all necessary components.

Functional Behavior Assessment Components	**Included**	**Not Included**
Review of historical records (e.g., educational, psychological reports, previous behavior support plans) and available data		
Identification and prioritization of socially significant behavior change goals		
Assessment of relevant skill strengths and deficits		
Preference assessment		
Describes functions of target behaviors		
Descriptive assessment and/or functional analysis of the target behaviors		
Interpretation of functional assessment data		

Quality of Individual Behavior Supports Plans

The following is an example of a brief checklist that might be created and utilized by Administrators to ensure that IBSPs include all necessary components.

Individual Behavioral Supports Plan Components	**Included**	**Not Included**
Intervention goals are objective and measurable		
Potential interventions are based on assessment results and are evidence-based		
Intervention goals and strategies are based on the individual's preferences, supporting environments, risks and constraints, and social validity		
When a behavior is targeted for reduction, an acceptable alternative behavior is selected to be established or increased		
Staff training on plan implementation		
Process for data-based monitoring of progress and need for plan revision		

Integrity of Individual Behavior Supports Plan/Emergency Intervention Plan Implementation

EBSH Administrators and QBMPs must train and support DSPs to ensure that the IBSPs and IEIPs are implemented as intended (i.e., with treatment integrity). DSPs should be knowledgeable about the proactive and reactive strategies specific to the individuals they support and be able to demonstrate their skills. It is recommended that a monitoring tool be developed to record DSP skill/competency for each individual they support. The following is an example of a checklist that might be created and utilized by Administrators and QBMPs for this purpose.

Name of Individual Being Served: _____			
Skill/ Competency	**Still Learning/ Needs Improvement**	**Mastered**	**Generalized (across settings)**

Integrity of Emergency Intervention Plan Implementation

With regard to the facility EIP, a similar checklist to the one for the IBSP/IEIP is recommended to ensure that it is implemented as intended. The checklist could be used in training and may also be a useful tool during debriefing meetings after the use of restraint.

Additionally, Title 22 §85322 (g)-(h) also requires that EBSH providers conduct and document an internal review of the use of restraint every six months. This is another opportunity to evaluate the integrity with which restraint and other emergency interventions are being implemented.

Reporting Requirements

The following table was created to assist EBSH providers in complying with all reporting requirements related to the use of restraint. It is the provider's responsibility to know the entirety of reporting requirements for EBSHs and to stay current with statute and regulations as what is included below may change over time.

Statute/Regulation	What to Report?	To Whom?	When?	How?
Title 22 §80061(b) and (g), (also, references to WIC §15630 below)	Unusual incident injury, death, abuse) related to restraint	Department of Social Services and client's authorized representative, if any	Next working day	Report
Title 17 §54327(b)(1)(B) and (D); Title 17 §54327(b)(2)(A)	Reasonably suspected abuse/exploitation, including physical and/or chemical restraint, serious injury/accident, death regardless of cause	Regional Center and client's authorized representative, if any	Within 24 hours Within 48 hours	Verbal report Written report
Title 22 §80061(b) (also, references to WIC §15630 below)	Unusual incident injury, death, abuse) related to restraint	Department of Social Services	7 days	Written report

Statute/Regulation	What to Report?	To Whom?	When?	How?
Title 22 §85361(b) (supersedes §80061(b) above)	Use of physical restraint	Department of Social Services	No later than next business day	Incident Report
Title 22 §85361(a)	Use of physical restraint	Client's authorized representative, if any	No later than next calendar day	By phone
Title 22 §85361(g)(h), Title 17 §59070(h)	Restraint log	Available to CDSS and DDS	Monthly	Written log
WIC §15630(b)(1)	Physical abuse resulting in serious bodily injury	Ombudsman, Law enforce, & Department of Social Services	2 hours	Telephone
WIC §15630(b)(1)	Physical abuse	Ombudsman, law enforce, & Department of Social Services	24 hours	Telephone and written report
WIC §4659.2(b)(1)(A)	Death or serious injury related to use of physical or chemical restraint	Disability Rights California	Close of next business day	Report
WIC §4659.2(c)(1)(B)	Number of incidents of behavioral restraint and time spent per incident of restraint	Disability Rights California	Monthly	Written report
WIC §4659.2(c)(1)(C)	Number of involuntary emergency medication used to control behavior	Disability Rights California	Monthly	Written report

Facility Program Plan Requirements

As per WIC §4684.81(i)(1), these Guidelines regarding the use of restraint or containment in EBSHs shall be maintained in the facility program plan and plan of operation. EBSHs certified and licensed prior to adoption of these Guidelines shall meet that requirement within 30 days of adoption (WIC §4684.81(i)(2)).

Periodic Review of Guidelines

These Guidelines will be reviewed periodically to ensure that they maintain their relevance and accurately reflect statute, regulations and/or best practices regarding the use of restraint and containment in EBSHs.

Acronyms

AAPT	American Association of Psychiatric Technicians
AAPT	American Association of Psychiatric Technicians
ABAI	Association for Behavior Analysis International
APBS	Association for Behavior Analysis International
APBA	Association of Professional Behavior Analysts
BACB	Behavior Analyst Certification Board
BCaBA	Board Certified Assistant Behavior Analyst
BCBA	Board Certified Behavior Analyst
BVNPT	Board of Vocational Nurses and Psychiatric Technicians
DSP	Direct Support Professional
EBSH	Enhanced Behavioral Supports Home
EIP	Emergency Intervention Plan
FBA	Functional Behavior Assessment
IBSP	Individual Behavior Supports Plan
IBST	Individual Behavior Supports Team
IEIP	Individual Emergency Intervention Plan
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
LPT	Licensed Psychiatric Technician
PBS	Positive Behavior Supports
PCP	Person Centered Practices (or Planning)
PCT	Person Centered Thinking
QBMP	Qualified Behavior Modification Professional
RBT	Registered Behavior Technician
WIC	Welfare and Institutions Code

Definitions

American Association of Psychiatric Technicians	A nonprofit organization that administers a voluntary national certification examination to test knowledge of psychiatric technology.
Behavior Analyst Certification Board	A nonprofit 501(c)(3) corporation established in 1998 to meet professional credentialing needs identified by behavior analysts, governments, and consumers of behavior analysis services.
Behavior Crisis or Emergency	A situation in which the individual is at risk for or imminently engaging in physical or emotional harm to self or others, or other target behaviors and is in immediate need for supports.
Board Certified Assistant Behavior Analyst	An undergraduate-level certification in behavior analysis through the BACB. Professionals who are certified at the BCaBA level may not practice independently, but must be supervised by someone certified at the BCBA/BCBA-D level. BCaBAs can supervise the work of Registered Behavior Technicians, and others who implement behavior-analytic interventions, but cannot conduct competency assessments for RBTs.
Board Certified Behavior Analyst/ Board Certified Behavior Analyst-Doctorate	An individual with a graduate-level certification in behavior analysis through the BACB. Professionals who are certified at the BCBA level are independent practitioners who provide behavior-analytic services.
Board of Vocational Nurses and Psychiatric Technician	The California BVNPT licenses vocational nurses (LVNs) and psychiatric technicians (PTs) and protects consumers from unprofessional and unsafe LVNs and PTs.
Containment	A brief physical (manual) restraint of a person for the purpose of effectively gaining quick control of a person who is aggressive or agitated or who is a danger to self or others. (Health and Safety Code §1180.1(b) and Title 22 §85301(c)(3))
De-escalation	Helping someone who is escalated stabilize back to their baseline so they can manage their own needs
Direct Support Professional	A person who assists an individual with a disability to lead a self-directed life and contribute to the community, assists with activities of daily living if needed, and encourages attitudes and behaviors that enhance community inclusion.
Enhanced Behavioral Supports Home	Homes certified by the Department of Developmental Services and licensed by the State Department of Social Services as adult residential facilities or group homes that provides 24-hour nonmedical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike setting. (WIC §4684.80(a))

Emergency Intervention Plan	As per Title 22 §85322(a), an Emergency Intervention Plan is a written plan that has to be developed and approved by the Department of Developmental Services prior to the use of restraint, if staff use, or it is reasonably foreseeable that staff will use, this technique. It must be designed and approved by the EBSH applicant or licensee in conjunction with a Behavior Management Consultant and must be part of the EBSH Plan of Operation (Title 22 §85322(a)(1)).
Functional Behavior Assessment	A variety of systematic information-gathering activities regarding factors influencing the occurrence of a behavior (e.g., antecedents, consequences, setting events, or motivating operations) including interview, direct observation, and experimental analysis.
Individual Behavior Supports Plan	An individualized plan developed by the QBMP with the IBST that contains strategies designed to teach or increase adaptive skills, reduce or prevent the occurrence of target behaviors through interventions that build on the individual's strengths.
Individual Behavior Supports Team	A team of individuals that includes, at minimum, the consumer, administrator, QBMP with the authorized representative, regional center representative, and clients' rights advocate, as appropriate to develop, monitor and revise IBSP. Meets at least monthly.
Licensed Clinical Social Worker	A licensed mental health professional who works in a sub-sector within the field of Social Work to help individuals deal with issues involving mental and emotional health.
Licensed Marriage and Family Therapist	A licensed mental health professional trained in psychotherapy and family systems, and licensed to diagnose and treat mental and emotional disorders within the context of marriage, couples and family systems.
Licensed Psychiatric Technician	A licensed person who provide hands-on care to people with varying degrees of mental illnesses and/or developmental disabilities and is licensed through the BVNPT.
Positive Behavior Supports	A is a set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in a person's environment. Positive behavior support combines: valued outcomes; behavioral and biomedical science; validated procedures; and systems change to enhance quality of life and reduce problem behaviors. (Association for Positive Behavior Supports)
Person Centered Planning	A way to assist people who need support in their life to construct and describe how they envision their life, their goals, what they need, and how they prefer their needs be met, to include purpose and meaning in their life. This typically includes paid and unpaid support and may or may not include publicly funded services.

Person Centered Practices	Any activity engaged in recognizing a person's capabilities and keeping the person's desired life/lifestyle as the primary focus which guides discussions, decisions and agreements regardless of professional or traditional service system priorities and available support.
Person Centered Thinking	A consistency in language, values and actions, which reveal respect, view person and their loved ones as the experts, and equally emphasizes satisfaction with quality of life and satisfaction with health/safety status.
Qualified Behavior Modification Professional	As per Title 17 §59050(v), a QBMP is an individual with a minimum of two years of experience in designing, supervising, and implementing behavior modification services and who is one of the following: (1) BCaBA; (2) BCBA; (3) LCSW; (4) LMFT; (5) licensed psychologist; (6) a professional with a California license, which permits the design of behavior modification intervention services.
Registered Behavior Technician	A paraprofessional who practices under the close, ongoing supervision of a BCBA, BCaBA, or FL-CBA through the BACB. The RBT is primarily responsible for the direct implementation of behavior-analytic services. The RBT does not design intervention or assessment plans.
Restraint	As per Health and Safety Code §1180.1(d) it is "the use of a manual hold to restrict freedom of movement of all or part of a person's body, or to restrict normal access to the person's body, and that is used as a behavioral restraint.
Target Behaviors	Specific behaviors exhibited by an individual that the consumer and IBST has identified for modification or reduction. Target behaviors could include, but not limited to, harm to self, others, or property.

Bibliography/Resources

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Association of Professional Behavior Analysts – http://www.apbahome.net

Behavior Analyst Certification Board – http://www.apbahome.net

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