Guidelines
for the
Use of Restraint or Containment
in
Community Crisis Homes

California Department of Developmental Services
March 2020

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Background

The Department of Developmental Services (Department or DDS) is committed to providing the services and supports needed for individuals with developmental disabilities to live in the most integrated settings. The Department developed these guidelines for the use of restraint or containment in Community Crisis Homes (CCHs) to be maintained in each facility's program plan and plan of operation. In development of these guidelines, the Department used the Guidelines for the Use of Restraint or Containment in Enhanced Behavioral Supports Homes and consulted with appropriate professionals and Disability Rights California regarding appropriate safeguards for the protection of individuals' rights.

The purpose of these Guidelines, although primarily to provide guidance to CCH 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 residing in CCHs, 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 remediating crisis situations in the least restrictive way.

> *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 with preventive, proactive strategies to avoid a crisis and on the use of less restrictive, non-physical reactive, crisis intervention strategies, 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 CCHs, 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, (e) pose a threat to their current placement and placement goals, and/or (f) 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 Community Crisis Homes

What are Community Crisis Homes?

CCHs are certified by the Department and licensed by the State Department of Social Services as residential facilities that provide 24-hour non-medical care to individuals with developmental disabilities in need of crisis intervention services who would otherwise be at risk of admission to an acute crisis center, a state-operated facility, an out-of-state placement, a general acute hospital, or an institution for mental disease (Welfare and Institutions (W&I) Code §4698(a)(1)). The crisis intervention services and supports provided include additional assessment, staffing, supervision, specialized staff training, and other intensive services and supports to immediately address an individual's urgent or emergent abrupt onset of behavioral or other needs (Title 17 §59000(j)). These services are provided under conditions which are the most integrated and the least restrictive possible to achieve the purposes of treatment (Title 17 §50510(a)(1)), beyond what is typically available in other community-based adult residential facilities or group homes to serve people in a community setting rather than an institution.

What is the Underlying Goal of Community Crisis Homes?

CCHs are intended to provide person-centered services and supports to help individuals successfully transition or return to their preferred community living option when the Individual Program Plan (IPP) team determines an individual is in need of crisis intervention services. The Regional Center will then assess the need for crisis intervention services that may lead to a determination of temporary placement in a CCH (W&I Code §59009(a)).

Within the context of person-centered practices, trauma-informed care and positive behavior supports, CCHs support the individuals who face challenges that may jeopardize their ability to have happy, healthy and safe lives in the community. Additionally, these supports provide services so that the need for acute crisis services or admission to acute psychiatric facilities or institutions for mental disease is minimized or prevented (Title 17 §59000(j)). CCHs emphasize individual goals and objectives that focus on stabilization and ameliorating issues that led to the need for crisis services. The maximum stay can extend to 18 months if needed. As such, goals and training objectives also include emphasis on the anticipated transition, so transition to a long-term placement can occur as quickly and safely as possible.

There are various types of CCHs, the Stabilization, Training, Assistance, and Reintegration (STAR) Program; Porterville Developmental Center Secure Treatment Area (PDC STA) Step-Down Homes; Institutions for Mental Disease (IMD) Step-Down Homes; and Community Crisis Homes for Children.

Transitions in the Community Crisis Home

Transition to the Community Crisis Home

Transition planning with goals and timelines should begin at admission and should be comprehensive, clear, and thoughtful. Prior to admission, the regional center shall assess the individual's need for crisis intervention services and include the assessment information in the documents provided to the CCH administrator or the person responsible for admission (Title 17 §59009(a)). This documentation may include physical, behavioral, and mental health assessments in addition to any other shared information that will facilitate a smooth transition to the facility and the development of the Individual Behavior Supports Plan (IBSP). When possible, preparing an individual for the transition to a CCH involves coordinating services with the individual (or the individual's representative), the regional center, the CCH, their prior placement or future long-term residential placement, as well as other providers to meet the individual's needs and promote continuity of care.

Preadmission meetings or visits held by the Individual Behavior Supports Team (IBST) create an opportunity to introduce the individual to their potential home, obtain critical information and share relevant documentation, coordinate the logistics of the transition including cross training opportunities, and determine the services and supports they need to return or transition to their preferred community living option. However, this should not delay an individual's admission to a CCH.

Transition from the Community Crisis Home

Planning for an individual's transition from the CCH begins at admission and should be revisited and updated as the individual progresses utilizing the IPP process with IBST. The transition plan should include, but not be limited to, the projected services and supports that would best serve the individual in the new living arrangement and a projected timeline for stabilization. Once the individual is approaching their stabilization goals and the regional center has identified a community option, the formal transition process should begin. This includes rate development of individual costs associated with transition (Title 17 §59022 (c)). The new residential provider will be involved in implementing all aspects of the discharge transition/treatment plan, including behavior management strategies. This process includes, but is not limited to:

- Identification of services and supports needed.
- Development of a plan for transition into the previous or preferred community living option.
- Individualized cross training for service providers to understand approaches and strategies. This will include what will be trained, how the new staff will be trained, and to what criterion.
- Day visits to the potential community living option to help facilitate the implementation of aspects of the discharge transition/treatment plan.

Once the transition plan is enacted, a transition meeting shall be held so the individual and their service provider have a seamless plan for final transition. At the time of the discharge, the CCH will develop a final summary of the individual's developmental, behavioral, social, health, and

nutritional status. A copy of the final summary, in addition to the current Functional Behavior Assessment (FBA) and IBSP, will be provided to the authorized personnel for transition support. A member of the IBST will provide a post discharge plan of care to the regional center and the new service provider to support the individual in adjusting to their new community living option.

Individual Behavior Supports Plans and Functional Behavior Assessments

Individual Behavior Supports Plans

From a person-centered perspective, services and supports should address the balance between what is important to and what is important for an individual. The idea of the balance between what is important to and what is important for an individual 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, 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.

IBSPs used prior to the individual moving to a CCH may contain effective strategies, replacement skill trainings, and known antecedents that can be the best starting point for the initial IBSP. If previous plans include restrictive interventions that are not allowed in CCHs (e.g., mechanical restraint, seclusion), they cannot be included in the initial IBSP. 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.

An IBSP is initiated immediately after an individual moves to a CCH and is completed within 24 hours (Title 17 §59010(b)). Then, within seven days, the CCH administrator (who meets qualification outlined in Title 17 §59004) ensures that all members of the IBST are contributing their input and makes a more comprehensive IBSP (Title 17 §59009(e)(2)). The IBSP identifies and documents the intensive support and service needs of the individuals with focus on difficult or challenging behaviors and details the strategies that will best enable the individual to return to their previous placement or to an appropriate alternative community-based environment (Title 22 §85301(i)(1)). The IBSP is informed by regional center documentation and assessments, may also include the requirements of Health and Safety (H&S) Code §1180.4(a) and identifies the entity or entities responsible for providing the services needed.

The CCH administrator and the IBST are to review the IBSP and update the plan, as necessary, on a weekly basis (Title 17 §59009(f)).

Individual Behavior Supports Plans

- The IBST is function-based, evidence-based, and targets functionally equivalent replacement behaviors, addresses individual needs and includes the following:

    1. Baseline of behaviors, needs or skill level
    2. Target behaviors, skills and attainable goals
    3. Function of behaviors
    4. Desired outcomes and replacement behaviors
    5. Intervention strategies; antecedent, instructional, and consequence strategies
    6. Entity/entities responsible
    7. Environmental changes
    8. Timelines and review dates
    9. Data collection, monitoring progress, and evaluation methods
    10. A written plan of transition to return to the previous placement or another appropriate community placement
    11. Emergency interventions that may be necessary

- The CCH administrator shall submit the IBSP and any updates to the vendoring and/or placing regional center service coordinator and, unless the individual objects on his or her own behalf, to the clients' rights advocate.

Functional Behavior Assessments

Conducting FBAs and the development of IBSPs initiated immediately and completed within the first 24 hours of placement should be viewed as the minimum standards. CCH providers, in coordination with their Qualified Behavior Modification Professionals (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 CCHs, it must be comprehensive. Best practice in conducting a comprehensive FBA includes direct observation of the individual, interviews with the individual 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 holistic 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, possible medical factors contributing to behaviors must be explored and 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 individual's life. (H&S Code §1180.4(a)(5)). Moreover, past incidents of restraint and psychiatric hospitalizations should be recognized as potentially traumatic experiences. Sensitivity to an individual's choices, 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 an individual'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 individual; teaching general, functionally-equivalent, functionally-related, and coping and tolerance skills; preventive/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.

<u>Delayed Egress and Delayed Egress/Secured Perimeter</u>

A CCH may utilize a delayed egress device on the exit(s) to the home, or the perimeter gate to the home provided the home has DDS certification for the use of these devices. The home may additionally use secured perimeter with the use of delayed egress devices with DDS Community Placement Plan approval and program certification. Delayed Egress (DE) devices are alerts on egress points on gates or doors that temporarily preclude the use of exits for a predetermined period of time. These devices shall not delay any resident's departure from the facility for longer than 30 seconds. Once the delay is released, DSPs may attempt to redirect an individual who

attempts to leave the home, especially if the situation is unsafe. If the CCH has DE/SP, annual written consents and/or court orders for individuals; and all components (e.g., alarms, locks) must be operational. (H&S Code §1531.1)

Delayed Egress/Secured perimeter (DE/SP) homes are built with higher fences and delayed egress gates and/or gates for individuals with high elopement or impulse control risks. Secured perimeter homes fence perimeter and height must meet requirements of California Building Codes (CBC) and California Fire Codes (CFC) and follow local city and county codes.

If the CCH has a delayed egress or delayed egress and a secured perimeter, the administrator shall ensure that the IPP includes a person-centered determination that the individual lacks hazard awareness or impulse control and requires the level of supervision afforded by the CCH equipped with delayed egress devices or delayed egress/secured perimeter. Additionally, if not for this placement, the person would be at risk for admission to, or would have no option but to remain in, a more restrictive state hospital or state developmental center placement. (H&S Code §1531.1-.15)

The FBA and IBSP should directly address how the individual's hazard awareness, impulse control, or other behaviors of concern that necessitates the use of delayed egress and/or secure perimeter is supported. The IBSP shall identify safety skills and replacement behaviors. The goal is for placement in the most integrated setting possible. The CCH model affords individuals the opportunity to live in the most integrated environment based on coping and safety skills assessed upon admission. Once placed in the CCH and coping and safety skills are learned and demonstrated, the door alarm or delayed egress may be turned off, the individual may learn how to use the code independently, or there may be a decrease in the intensity of staff support.

For DE or DE/SP, the IBSP shall include a plan for how individuals will be taught safety awareness, impulse control, and other skill trainings to increase their level of safety in the neighborhood with the goal to ultimately live in the most integrated setting possible. Additionally, IBSP strategies may also address safety skills, target behaviors and training. The delayed egress system can be modified to be turned off or set to a shorter duration of time depending on individuals' needs and some individuals can gain access to codes or keys to egress doors without the door locking.

Staff Training on DE and DE/SP

The CCH shall provide staff training regarding the use and operation of the delayed egress and delayed egress/secured perimeters, protection of residents' personal rights, lack of hazard awareness and impulse control behavior, and emergency evacuation procedures. All staff must be trained in individual rights regarding the delayed egress system and must understand that individuals retain the personal right to come and go from their home. (H&S Code §1531.15; Title 22 §80068 and §80070; Title 17 §56070–56073)

Individual Behavior Supports Team

The IBST are individuals who participate in the development, revision and monitoring of the IBSP for individuals residing in a CCH.

Individual Behavior Supports Team
The IBST includes at minimum, the: 1. Individual and, where applicable, authorized consumer representative; 2. Regional center service coordinator and another regional center representative as necessary; 3. CCH administrator; 4. Regional center clients' rights advocate, unless the individual objects on his or her own behalf to participation by the clients' rights advocate; and 5. CCH QBMP. The team may also include: 6. Mobile crisis service; 7. Representative(s) from the individual's prior residence and/or identified alternative future community-based residential setting, as applicable; 8. Health Care Professional; or 9. Anyone deemed necessary by the individual, or, where applicable, his or her authorized consumer representative, if any, for developing a comprehensive and effective IBSP.

As noted above, the IBST includes the regional center clients' rights advocate. CCH providers need to contact the Office of Clients' Rights Advocacy (OCRA, a program of Disability Rights California) to identify the Clients Rights' Advocate (CRA) 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 CRA list can be found on the following webpage: https://www.disabilityrightsca.org/what-we-do/programs/office-of-clients-rights-advocacy-ocra

The goal of an individual's support team is presumably to help the individual 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 individual wants, 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 §59009(f) also notes that the CCH administrator is required to review the IBSP weekly and provide updated information as necessary. The CCH administrator must determine the structure of these weekly 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. 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. Also, if law enforcement was involved in response to a crisis, the team may want to meet.

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 individual 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.

Individuals' Rights and Denial of Rights

Individuals' Rights

All individuals with developmental disabilities are entitled to the same rights, protection, and responsibility as all other persons under the laws and Constitution of the State of California and the United States, unless restricted by law (Title 17 §50510). Individuals are encouraged to exercise their rights at will. Special attention and effort shall be given from providers to ensure that these human and civil rights are exercised, protected, and implemented, not only while residing in a CCH, but also in receiving needed services. Providers must have a copy of conservatorship documents when applicable to understand what rights the consumer retains, as there are various types of conservatorships. Rights are listed below as access rights and personal rights for people temporarily residing in a CCH.

Access rights include, but are not limited to (Title 17 §50510(a)):

1. Treatment and habilitation service and support should foster the developmental potential of the individual and be directed toward the achievement of the most independent, productive, and normal life possible. Such services should protect the personal liberty of the individual and shall be provided with the least restrictive conditions necessary to achieve the purposes of the treatment, services, or supports.
2. Dignity, privacy, and humane care. To the maximum extent possible, treatment, services, and supports shall be provided in natural community settings.
3. Participation in an appropriate program of publicly supported education, regardless of disability.
4. Prompt medical care and treatment, and to be fully informed of health and condition, as indicated.

5. Religious freedom and practice include the right to attend services or to refuse attendance, to participate in worship or not to participate.
6. Social interaction and participation in community activities.
7. Physical exercise and recreational opportunities.
8. Freedom from harm, including unnecessary physical restraint or isolation, excessive medication, abuse, or neglect.
9. Freedom from hazardous procedures.
10. The exercise of choices in their own lives, including but not limited to: where and with whom they live; relationships with people in their community; the way they spend their time, including education, employment, and leisure; the pursuit of their personal future; and program planning and implementation.
11. Advocacy services to protect and assert the civil, legal, and service rights to which any individual having a disability is entitled.
12. Freedom from discrimination by exclusion from participation in, or denial of the benefits of any program or activity which receives public funds, solely by reason of being an individual with a developmental disability.
13. Access to the courts for purposes including, but not limited to:
    - Protecting or asserting any right to which any individual with a developmental disability is entitled.
    - Questioning a treatment decision affecting such rights, once the administrative remedies provided by law or regulation have been exhausted.
    - Inquiring into the terms and conditions of placement in any community care or health facility or state developmental center by way of a writ of habeas corpus.
    - Contesting a conservatorship, its terms, and/or the individual or entity appointed as guardian or conservator.

Personal rights include, but are not limited to (Title 17 §50510(b)):

1. To keep and be allowed to spend one's own money for personal and incidental needs.
2. To keep and wear one's own clothing.
3. To keep and use one's own personal possessions, including toilet articles.
4. To have access to individual storage space for one's private use.
5. To see visitors each day.
6. To have reasonable access to telephones, both to make and receive confidential calls, and to have calls made for one upon request.
7. To mail and receive unopened correspondence and to have ready access to letter-writing materials, including sufficient postage in the form of United States postal stamps.
8. To refuse electroconvulsive therapy ("ECT").
9. To refuse behavior modification techniques which cause pain or trauma.
10. To refuse psychosurgery. Psychosurgery means those operations currently referred to as lobotomy, psychiatric surgery, and behavioral surgery and all other forms of brain surgery if the surgery is performed for any of the following purposes:
    - Modification or control of thoughts, feelings, actions, or behavior rather than treatment of a known and diagnosed physical disease of the brain.
    - Modification of normal brain function or normal brain tissue in order to control thoughts, feelings, actions, or behavior.

- Treatment of abnormal brain function or abnormal brain tissue in order to modify thoughts, feelings, actions, or behavior when the abnormality is not an established cause for those thoughts, feelings, actions, or behavior.

11. Other rights as specified by administrative regulations of any federal, state, or local agency.

Notification of Rights

Per Title 17 §50520, individuals with developmental disabilities are informed of their rights, in the language they comprehend, at the time of admission or transfer, when there is a change in legal status, or when a conservator has been appointed. Notices of rights, in both English and Spanish (and other languages deemed appropriate by the Department of Developmental Services), are posted. The individual's disability shall not limit ability to fully exercise his/her legal and civil rights.

1. All individuals shall be personally informed of all rights to which he or she is entitled in a language or other form of communication, which he or she understands, including a printed copy when appropriate. If an individual cannot be effectively informed of his or her rights, a good faith effort must be made and witnessed. The person witnessing the good faith effort shall also sign the documentation.
2. Notification of rights must also be given to the individual's parent, guardian, conservator, or responsible family member. This notification shall occur on the following occasions:
    a. Within 24 hours after admission to the facility.
    b. Upon change in legal status, such as when a conservatorship is established.
    c. Upon request, or as needed.

<u>Denial of Rights</u>

A good cause exists only if exercising the right would (1) cause injury to the individual; (2) seriously infringe on the rights of others; or (3) cause serious damage to the facility. A good cause must also ensure that there is no less restrictive way of protecting the interests of the three causes and that the good cause is related to the specific right that is denied. Legally, a right shall not be withheld or denied as a punitive measure or considered a privilege to be earned. Additionally, legally good cause is not a treatment modality, approach, or plan. (Title 17 §50530)

Personal rights that **cannot be denied** for good cause, include, but are not limited to:

1. Refuse electroconvulsive therapy.
2. Refuse behavior modification techniques that cause pain or trauma.
3. Refuse psychosurgery.
4. Make choices in areas such as, daily living routines, choice of companions, leisure and social activities, and program planning and implementation.

Personal rights that **may be denied** for good cause which include, but are not limited to (Title 17 §50530(a)):

1. Keep and be allowed to spend one's own money for personal and incidental needs.
2. Keep and wear one's own clothing.

3. Keep and use one's own personal possessions, including toiletries.
4. Have access to individual storage space for private use.
5. See visitors each day.
6. Have reasonable access to telephones, both to make and receive confidential calls.
7. Have ready access to letter-writing materials, including stamps, and to mail and receive unopened correspondence.

Assessment of Rights

Upon identifying the potential or actual need to deny a right, staff will first need to identify and implement or attempt all less restrictive means of protecting the individual from injury or harm, protecting others from having their rights violated or causing serious damage to the facility.

Disability Rights California's Office of Clients' Advocacy recommends the following assessment strategy for providers to answer to determine whether a denial of rights is needed for Good Cause:

1. *Did you discuss the potential denial of right with the individual? What are his/her thoughts?*
2. *Are individuals' rights involved? What rights? Is the right involved one from the list of rights that may be denied for good cause?*
2. *Are there imminent health and safety issues? Is there imminent risk for damage to property? Are the risks imminent, reasonable or excessive?*
3. *Are other individuals' rights involved or somehow harmed?*
4. *What would be the least restrictive intervention? For example, could the right be limited instead of completely denied?*
5. *Is the right denied related to the reason for the denial?*

If a Denial of Rights seems necessary to protect the individual or others, an IBST meeting will be held. The individual, their family/legal representative, the placing regional center and CRA will be requested to participate.

Any potential denial of right must be discussed with the regional center coordinator and approved by the CRA. To receive sign off from the CRA, there must be (1) data to justify the denial and that lesser restrictive techniques were considered and attempted; and (2) a plan for reinstatement of the right that is being denied. A determination must be made that the denial is necessary and meets the good cause requirements. The CCH administrator or designee has the authority to deny an individual's personal rights as indicated above, for good cause.

Documentation of a Good Cause Finding

If there is good cause, the professional person in charge or designee must:

1. Notify the individual of the right to appeal, waive the right, and/or leave the facility, if applicable (Title 17 §50532(a)).
2. Immediately document the following information in the individual's record (Title 17 §50532(b)).

a. If an emergency prevents immediate documentation, it must be done within 24 hours and a special incident report must be submitted to DDS that includes:
    i. Date/time right denied
    ii. Specific right denied
    iii. Specific Good Cause for denial
    iv. Names of any staff involved in decision
    v. Signature of professional or designee authorizing denial
    vi. If individual appealed, date of request and appeal outcome
    vii. Plan for reinstatement
    viii. Date of proposed 30-day review
    ix. Date right restored
3. Send the original documentation to the CRA immediately or within 24 hours and a copy to the regional center service coordinator not to exceed 10 days (Title 17 §50536(a)).
4. Retain a copy in the individual's file.

Reinstatement Procedure

Upon the denial of a right, a plan for reinstatement shall be initiated. A reinstatement plan is a requirement for the good cause for denial to be approved by the CRA.

Upon expiration of the good cause, any denied right shall promptly be reinstated. A right shall not continue to be denied when the good cause for the denial no longer exists. For assessment of the continued validity of the good cause upon which the denial is predicated, each denial for good cause shall be reviewed at a minimum of thirty (30) days beginning from the first date when the denial takes place. At each review, a specific finding shall be made that the good cause for continuing the denial exists, including that it is still the least restrictive means, or the denial shall terminate.

<u>Responsibility to Ensure Individuals' Rights</u>

Providers who support individuals who experience crisis play an important role in helping protect individuals' rights. Below is a list of key professionals and their responsibility to ensure individuals' rights.

CCH Administrator/Professional Person in Charge/Designee

- Ensures the facility is in compliance with the posting requirement of rights (Title 17 §50520(b)(1)).
- Ensures individuals are notified of their rights and ensures that documentation of such notification is completed.
- Reviews proposed denial of rights and ensures that rights are denied only for good cause. If in agreement, signs and dates the Denial of Rights Report, ensures that this is properly documented and reported to the CRA (Title 17 §50530(b)).
- Advises the individual, or if unable to comprehend, the individual's parent or guardian, if a minor, conservator, personal or legal representative, of the right to elect to leave the facility

without submitting to the proposed denial or to submit to the denial but appeal its basis (Title 17 §50530(h)).
- Ensures a copy of the Denial of Rights Report is served upon the individual or the individual's legal representative.

Individual Behavior Supports Team (IBST)

- Ensures that the need for training for the exercising of rights and the responsibilities involved, is addressed in the IPP.
- Meets to assess whether less restrictive methods can be employed before a right is denied.
- Documents the good cause for denying a right and develops a plan for reinstating the right.
- Determines a schedule for re-evaluation of the denial of rights no less than every thirty (30) days.

Clients' Rights Advocate

- To assure that rights of individuals served by the regional center, including applicants and individuals referred for services, are guaranteed, protected, and asserted as requested by or on behalf of the individual (Title 17 §50550(b)(1)).
- To monitor compliance with the posting requirements and the notification of rights in any licensed facility (Title 17 §50550(b)(2).
- To investigate and to facilitate resolution of all complaints involving violation, withholding or punitive denial of rights which are brought by or on behalf of any individual (Title 17 §50550(b)(3)).
- To initiate inquiry into any violation, withholding or punitive denial of any right to which an individual is unable to do so (Title 17 §50550(b)(4)).
- To assist individuals in the pursuit of administrative and legal remedies. If the complaint is against an employee, a policy, or the operations of the regional center, the CRA may refer the individual to any agency which can provide representation (Title 17 §50550(b)(5)).
- To advise the regional center director on the development and implementation of the regional center clients' rights assurance program (Title 17 §50550(b)(6)).
- To serve as a local consultant and resource person on the issue of rights for individuals, families, regional center staff and other interested persons (Title 17 §50550(b)(7)).
- To act as the liaison between the regional center and the Clients' Rights Office.
- To review and monitor all reports concerning the denial of rights for good cause that are submitted (Title 17 §50550(b)(8)).

<u>The Appeal Process</u>

Each individual or any representative acting on behalf of an individual who believes that any right to which the individual is entitled has been abused, punitively withheld, or improperly or unreasonably denied, may pursue a complaint. Initial referral of any complaint shall go to the CRA. (Title 17 §50540)

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. CCH providers are required to develop emergency intervention plans for both the facility and their individuals at the time of admission per Title 17 §59002(a)(3).

As defined in Title 17 §59000(n), 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 (Title 22 §85161(a)-(h)).

The regulations that guide the use of emergency interventions in CCHs, 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. This includes the practice of only using more restrictive interventions after less restrictive strategies have been determined to be ineffective. These Guidelines provide supplemental information about a continuum of emergency interventions/reactive strategies and methods for measuring their effectiveness to assist CCH providers in developing both their facility Emergency Intervention Plans (EIPs) and Individual Emergency Intervention Plans (IEIPs) for the individuals they serve.

Facility Emergency Intervention Plans

The facility EIP regarding the use of restraint should be designed by the CCH applicant or licensee in conjunction with a Behavior Management Consultant and as a part of the facility program plan per Title 17 §59002(a)(8)(D). As such, the facility's program plan and the EIP is to be approved by the Department.

The facility EIP should specify the least restrictive, or non-physical de-escalation methods that are used to identify and prevent behaviors that could lead to the use of restraint. Restraint means any intervention, including a physical hold, that restricts an individual's freedom of movement of all or part of an individual's body. The EIP must also specify those strategies, including the use of restraint, 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, the use of a continuum of interventions starting with the least restrictive is required. Furthermore, only when those less restrictive interventions have proven ineffective, can a more restrictive intervention, such as restraint, be used and only when an individual's behavior presents an imminent danger of serious injury to self or others.

Seclusion is never to be used in a CCH (Title 17 §59001). Seclusion involves placing an individual in a room or area against his/her will and from which he/she is physically prevented from leaving. No individual 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 should include, but are not limited to, the following items:

- Staff qualifications are 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 H&S 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 that individual into their daily routine after the need for an emergency intervention has ceased.
- Procedures for how the CCH will establish positive ongoing relationships with local law enforcement, local mental health crisis services, and mobile crisis services.
- Procedures for how the CCH staff are trained on how and when to contact local law enforcement, local mental health crisis services, and mobile crisis services, as a last resort, and how DSPs are to respond when police, local mental health crisis services, and mobile crisis services arrive.

Additionally, the EIP should include a training plan that outlines the following components:

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 CCH.

More information about emergency intervention training can be found in the Staff Training section in this document. 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, CCH 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 (H&S Code §1567.64).

Much conceptual and applied work in 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 guidance 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 CCH 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, CCH 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 the message the individual 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 individual time to focus on using coping strategies.
Changing proximity	Move away from or closer to the individual 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.

Reactive Strategies	Definitions
Facilitating relaxation	Provide instructions to promote relaxation and calm based on the coping skills the individual 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 individual to a powerfully preferred or compelling event or activity.
Strategic capitulation	Giving in to the communicative message of the individual's behavioral incident, e.g., withdrawing demands, giving the individual 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 the individual without physically guiding them to continue engagement and supports.

Providers are prohibited from using punitive strategies in reaction to crisis situations, as punishment is not a deterrent and may increase aggression. This is in direct conflict with the goal of a reactive strategy, which is to resolve a crisis 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 individual 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, CCH providers are strongly encouraged to evaluate their own and/or their staff's 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).

As a last resort measure, CCHs may need to utilize emergency measures such as contacting local law enforcement, local mental health crisis teams, or other mobile crisis services. Prior to opening the CCH, it is best practice for the CCH administrator to identify the local law enforcement, mental health services, and mobile crisis services in the area and contact them. Administrators may invite the local law enforcement, mental health services, and mobile crisis services to the CCH to see the physical layout of the CCH, meet other CCH staff, learn about the program and consumers served, and share contact information, such as the administrator's contact information, house phone number, and regional center contacts. The administrator can maintain contact with these services throughout the stay, even when services are not being used.

Additionally, the EIP must include a plan to train staff on how and when to call local law enforcement, local mental health crisis services, and mobile crisis services. as a last resort. Contacts for these services must be made easily available to DSPs. The EIP must require that the Individual Emergency Intervention Plan specify when these services are to be utilized in the emergency plan. The EIP must specify how DSPs are adequately trained on how to respond when local law enforcement, local mental health crisis services, and mobile crisis services are called. Mental health services and mobile crisis services may be more likely to be trained on best approaches to deescalate situations. Local law enforcement may require prompts when they arrive on scene that the situation is different than most others. DSPs should be trained when they call 911 to identify themselves as a DSP for a CCH for consumers with a developmental disability. If possible, have one DSP wait outside to greet the officers to identify themselves and the situation. When officers arrive, identify themselves as quickly as possible as DSPs and notify officers of the consumer's disability. For consumers who have required multiple calls to local law enforcement, local mental health crisis services, and mobile crisis services, offer to debrief with those services and develop written plans to deescalate situations with the least amount of force, restraint, or use of hospitalization possible. The EIP must state that each incident that involved local law enforcement, local mental health crisis services, and/or mobile crisis services, requires incident debriefing and the IBST review of the IBSP.

Individual Emergency Intervention Plans

In addition to the facility EIP, CCH providers should also develop IEIPs for the individuals they serve. The IEIP is based on the initial assessment that is completed prior to placement in the CCH, as a required component of the IBSP (Title 17 §59010). The Department recommends one unifying document for ease of training staff and ensuring consistent implementation of all proactive and reactive strategies, including emergency interventions.

As defined in Title 22 §89901(i)(3) for Enhanced Behavioral Support Homes, an IEIP in a CCH is "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 QBMP, with input from the individual and if available, someone whom he or she desires to

provide input in accordance with H&S Code §1180.4(a). The plan shall include person-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 H&S 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. An individual's advanced directive regarding de-escalation or the use of seclusion or behavioral restraints. However, seclusion is prohibited in CCHs, even though it is included in the H&S Code (Title 17 §59001(g)).
2. Identification of early warning signs, triggers, and precipitants that cause an individual to escalate, and identification of the earliest precipitant of aggression for individuals with a known or suspected history of aggressiveness, or individuals who are currently aggressive.
3. Techniques, methods, or tools that would help the individual control his or her behavior.
4. Preexisting medical conditions, any physical disabilities, or limitations that would place the individual at greater risk during restraint or seclusion.
5. Any trauma history, including any history of sexual or physical abuse that the affected individual feels is relevant.
6. Address how the consumer may respond if local law enforcement, local mental health crisis services, and mobile crisis services are used as a last resort measure. Include a review of any trauma history with past experiences.
7. Address plans for when to contact local law enforcement, local mental health crisis services, and mobile crisis services, as a last resort, and how DSPs are to respond when local law enforcement, local mental health crisis services, and mobile crisis services arrive, and what behaviors of concern and possible reactions the consumer may have as a result of the last resort measure.

The IEIP must be individualized and updated as needed to ensure it meets the safety needs of the individual. Minimally, the IBST is encouraged to review and revise, as needed, the IEIP following each restraint event as the use of restraint may indicate failure of the IEIP to identify individual triggers and/or individualized strategies to effectively de-escalate 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.

While the CCH EIP provides a toolbox of emergency interventions/reactive strategies that staff may use to help an individual 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 individual's placement in a CCH, through the FBA process and in the development of the IBSP. In addition to gathering information about their medical conditions, physical limitations and trauma history; psychological and medical contraindications to 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.

The IEIP can be useful in managing a crisis and in reducing or avoiding the use of restraint. 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, 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. If restraint is used as an emergency intervention, the regional center should notify the Department.

Development of the IEIP is meant to be a collaborative effort that includes the individual. It is intended to help them 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 their individuals 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, 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 they 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, CCH 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. CCH 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, CCH 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 this individual? Were there techniques in the individual's IBSP or IEIP that were used but were not effective? Should the IBSP or IEIP be revised to include additional or alternate intervention techniques?* This is not done to be punitive, but rather to evaluate the circumstances in a way that upholds the individual's dignity and respect. It 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, CCH providers must assess and monitor the use of restraint and ensure that it is only used as a last resort measure. CCH 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 (if separate from the IBSP) to ensure that the most effective and least restrictive strategies are used to avoid or quickly de-escalate an imminent crisis.

Restraint and Containment

CCH 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 CCH providers support individuals with complex needs and some trigger events may not always be prevented. In circumstances when restraint is used, it is the CCH 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 the individual's relationships with support staff and have short- or long-term effects on their mental health. For example, it can generate shame, embarrassment, trauma, 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 health and/or safety and only when less restrictive methods have been ineffective in resolving a crisis 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 CCHs shall not utilize seclusion, which is also consistent with Title 17 §50515(a) stating that no individual 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.106107)

Summary of Laws and Regulations

A multitude of laws and regulations exist regarding the use of physical restraint or containment. Many of the regulations referenced here address both the use of physical restraint and seclusion. However, Title 17 §59001(g) clearly states that CCHs shall not utilize seclusion, which is also consistent with Title 17 §50515(a) stating that no individual with a developmental disability shall be placed in seclusion.

Throughout this document, the term "restraint" is used to mean physical restraint. Within the H&S Code §1180.1, the terms "manual restraint" and "behavioral restraint" are used synonymously.

Definitions of Restraint and Containment

Restraint means any intervention that restricts an individual's freedom of movement of all or part of their body, or normal access to the individual's body, and that is used as a behavioral restraint. Restraint includes physical restraint, also referred to as manual restraint, the use of emergency medication, and mechanical restraint. Mechanical restraint is prohibited in CCHs.

Manual restraint techniques include, but are not limited to, forced escorts; holding; wall restraint; brief prone containment; or any staff-to-individual physical contact in which the individual 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." (H&S Code §1180.1(d))

Containment is defined in H&S Code §1180.1(b) 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." (H&S Code §1180.1(b))

In a CCH, consumers shall be assisted as needed with self-administration of prescribed and non-prescribed medications. Facility staff, except those authorized by law, shall not administer

injections, but authorized designated staff may assist consumers with self-administration of injections as needed. Consumers have a right to refuse medications and providers shall not force a consumer to take a medication or hide or camouflage medications in food or other means without the consumer's knowledge or consent. If a consumer is refusing a medication in any manner, staff shall talk with the consumer on the reasons why they are refusing medication and document the reasons. If the consumer refuses medication, follow all appropriate notifications. A consumer can be assisted with the self-administration of PRN medication when the consumer voluntarily assists themselves to gain self-control. (Title 22 §80075)

Restraint may only be used when there is clear evidence for believing the existence of an imminent danger to either the individual or others if such restraint is not accomplished. The two critical features of restraint are that (1) restraint or containment limits a person's voluntary movement and (2) restraint is solely used for keeping the person from causing serious harm to self or others. All support staff should have knowledge of the aforementioned definitions.

The Use of Restraint as a Last Resort

Restraint may be used as a last resort emergency intervention in limited, unforeseen circumstances to protect the safety of an individual or others. Restraint may only be used by support staff who are trained in the proper use of restraint. Staff not trained in restraint procedures (or not up-to-date in restraint training certification) should not restrain individuals. There must be a real possibility of serious physical harm or risk to someone's life or health if no action is taken. There also must be documented evidence that less restrictive, nonphysical strategies were attempted first and without success.

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 use restraint, it must be done in accordance with all laws and regulations and in compliance with an authorized training program and the CCH facility EIP and the IEIP. Restraint is never to be used to control or manage 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 protecting the safety of the individual and others from an imminent risk of physical harm. 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 their 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. The assigned staff must always be able to visually observe the individual and should be able to hear and be heard by them. 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 staff member 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

The emergency interventions that are prohibited in all community care facilities, including CCHs include the use of:

- Mechanical restraint;
- Seclusion;
- Restraint as an extended procedure;
- Restraint when imminent risk or serious physical harm is no longer present;
- Emergency interventions that are used for punishment, discipline, harassment, humiliation, coercion, or 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 H&S 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 per H&S Code §1180.4(h).

Furthermore, 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 IBSP. 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 him/her or others. Restraint is never to be used when an individual has a medical or physical condition that could endanger their life or when it could worsen their medical condition. Nor can it be used if it is prohibited in the CCH facility EIP or the IEIP.

Concerns about Prone Containment

As per H&S Code §1180.4(f), community care facilities, including CCHs, 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, a staff member shall observe the individual for any signs of physical duress throughout the use of prone containment. Whenever possible, the staff member monitoring the individual shall not be involved in restraining the person." Of note, best practice, without exception, is for a trained staff who is not involved in restraining the individual to constantly monitor the restraint and the individual's condition, and the situation, not merely "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.

Alternative restraint positions to prone containment are strongly advised. CCH 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. CCH 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 restraint compromising breathing and potential risk factors that increase the likelihood of injury.

Time Limits on the Use of Restraint

When restraint is used, it needs to be kept at an absolute minimum in terms of duration 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.

The Department advises restraint not to continue longer than necessary to control the behavior for which the restraint was employed. CCHs, specifically, must ensure that physical restraint is not used as an extended procedure and per H&S Code §1180.4(h), that physical restraint is not to be used for more than 15 consecutive minutes.

The only exception to the 15-minute limitation is when there is a continued need to protect an individual's immediate health and safety from imminent danger and there is concurrent approval obtained by the CCH 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 if an exception to the 15-minute limit must be made. This includes required documentation in the individual's record of the CCH administrator's approval within 24 hours, with an explanation of why it was necessary for restraint to go beyond 15 minutes and a detailed description of the 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 CCH administrator or administrator's designee. This must be an in-person communication to assess their physical well-being. An assessment by a qualified medical professional is

recommended to determine whether there is physical injury or suspected physical injury and whether a medical examination is needed. If medical attention is sought, it must be documented in the individual's record and reported to the Department. If suspected physical injury or a complaint of physical injury are reported to or witnessed by staff during or after the restraint, it must be reported to the CCH administrator or administrator's designee immediately. In this case, a written incident report must be submitted to the Department of Social Services and the regional center (Title 17 §54327). The regional center then submits the report to the Department. 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. They should be treated for trauma. CCH 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

CCH 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. H&S Code §1180.5 describes the debriefing process that must occur after each episode of the use of restraint.

CCHs 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, their 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 CCH 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 and should also be in attendance.

Debriefing activities include:

- Identifying what led 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 their 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 if they refuse to participate in the review.

If the individual refused to participate in the debriefing, CCH providers are encouraged to seek input 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 individual 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:

- *Do you know why we had to use a restraint?*
- *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 is 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 individual and the IBST meet. The individual's IBSP, the individual's ongoing support and transition 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 CCHs.

CCH Staff Qualifications

Staff requirements must follow Title 22 §80065 and 85066. In addition, the table below shows the staffing requirements specific to CCHs as per Title 17 §59005 and §59006, and Title 22 §85365 for the Direct Care Staff (Direct Support Professional) and Direct Support Lead. Qualifications for the Qualified Behavior Modification Professional use the definitions stated in the regulations for Enhanced Behavior Support Homes, Title 22 §59050 and §59004.

Qualifications	Administrator	Direct Support Lead	Direct Support Professional (DSP) or Direct Care Staff	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 an RBT within 60 days of initial employment; or be (A) A qualified behavior modification professional	Must become an RBT within 12 months of initial employment; or be (A) A qualified behavior modification professional	Must be: (1) An Assistance Board Certified Behavior Analyst (BCBA) 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 (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 CCH providers recruit QBMPs who meet the minimum qualifications 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
Reference qualifications for CCH are consistent with those required by Title 17 §59050(v) for Enhanced Behavioral Support Homes.
Experience working with adults with significant challenging behaviors (and/or with children if the CCH 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.
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 CCHs and on the use of restraint.

Another consideration when selecting a QBMP is whether the CCH 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 (https://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 CCH 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 following table shows the training requirements for all DSPs working in CCHs, that includes RBTs, LPTs or QBMPs.

Statute/Regulation	Training Requirement	Hours Required	By When
Title 17 §59007, Title 22 §80065(f), §85365	On-site orientation	32 hours	Within first 40 hours of employment
Title 17 §59007(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, W&I Code §4695.2	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
W&I Code §4698.1, Title 17 §59007, Title 22 §85365, H&S Code §1567.64	Emergency intervention training	16 hours	Prior to implementing emergency intervention techniques
Title 17 §59008, 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, restraint avoidance, de-escalation and emergency intervention training is of importance. CCH 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, the EIP includes an emergency intervention training plan.

In accordance with Title 22 §85365(j), a DSP is prohibited from implementing 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 of CCH staff must include a minimum of 16 hours of instruction 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 a 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 17 §59000(n)). Therefore, CCH 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 these Guidelines).

The Department does not endorse any one curriculum. The following list is offered as a resource for CCH 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. CCH 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.therapeuticoptions.com/
- Ukeru Systems (Grafton Method) – www.ukerusystems.com/

The Department encourages CCH 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 CCH 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 CCHs
Components included in curriculum 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 a crisis 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 §85365(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 §85365(h) – specialized needs of each individual; individual rights and protections; facility program plan; implementation of the individual's IPP; health and emergency procedures (including fire safety); a disaster and mass casualty plan; identification and reporting of incidents and suspected abuse and neglect; and assistance with prescribed medications and documentation.

The Department requires that CCHs 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 individual. CCH providers need to incorporate the details of these additional training hours into the facility program plan.

Data Collection, Monitoring and Reporting

Data Collection

CCH facility plans are required to include the methods they will use to measure an individual's progress (Title 17 §59013(b)). This includes the types of data to be collected, including data regarding the use of emergency interventions. CCHs 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 requirements of W&I Code §4695.2 (Title 17 §59011).

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 written plan of transition to return to the previous placement or another appropriate community placement. 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. CCH 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. 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; events leading up to escalation of the individual; the rationale for the use of restraint; what less restrictive, non-physical interventions were used and why more restrictive interventions were needed; and their 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. CCH providers must ensure compliance with these and other documentation and reporting requirements.

Monitoring

Quality of Functional Behavior Assessments

The following table is an example of a brief checklist that might be created and utilized by CCH administrators to ensure that QBMPs are conducting FBAs within the first seven days of placement that include all necessary components.

Functional Behavior Assessment Components	Included	Not Included
Review of historical records (e.g., educational, psychological reports, medical 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 table is an example of a brief checklist that might be created and utilized by CCH 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		
Medical factors affecting behavior eliminated		

Integrity of Individual Behavior Supports Plan/Emergency Intervention Plan Implementation

CCH 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 table is an example of a checklist that might be created and utilized by CCH 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

Regarding 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, CCH providers are recommended to conduct and document an internal review of the use of restraint quarterly. This documentation should be used to identify possible trends in frequency and location of restraint. 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 CCH providers in complying with all reporting requirements related to the use of restraint. Regional centers are required to report incidents or use of restraint to the Department. It is the provider's responsibility to know the entirety of reporting requirements for CCHs 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 W&I Code §15630 (below)	Unusual incident injury, death, abuse) related to restraint	Department of Social Services and individual'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 individual's authorized representative, if any	Within 24 hours Within 48 hours	Verbal report Written report
Title 22 §80061(b) also, references to W&I Code §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	Individual'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 Department of Social Services and DDS	Monthly	Written log
W&I Code §15630(b)(1)	Physical abuse resulting in serious bodily injury	Ombudsman, law enforcement, & Department of Social Services	2 hours	Telephone
W&I Code §15630(b)(1)	Physical abuse	Ombudsman, law enforcement, & Department of Social Services	24 hours	Telephone and written report
W&I Code §4659.2(b)(1)(A)	Death or serious injury related to use of physical or chemical restraint	Disability Rights California, Investigations Unit/Program	Close of next business day	Report DRC website link
W&I Code §4659.2(c)(1)(B)	Number of incidents of behavioral restraint and time spent per incident of restraint	Disability Rights California Investigations Unit/Program	Monthly	Written report DRC website link
W&I Code §4659.2(c)(1)(C)	Number of involuntary emergency medication used to control behavior	Disability Rights California Investigations Unit/Program	Monthly	Written report DRC website link

Facility Program Plan Requirements

As per W&I Code §4698(d)(1), these Guidelines regarding the use of restraint or containment in CCHs must be maintained in the facility program plan and plan of operation. CCHs certified and licensed prior to adoption of these Guidelines shall meet that requirement within 30 days of adoption.

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 CCHs.

Acronyms	
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
CCH	Community Crisis Home
CRA	Clients' Rights Advocate for the Office of Clients' Rights Advocacy
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
W&I Code	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 individuals 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 (LPTs) and protects individuals from unprofessional and unsafe LVNs and LPTs.
Community Crisis Home	Residential facilities that provides 24-hour non-medical care to individuals with developmental disabilities in need of crisis intervention services who would otherwise be at risk of admission to an acute crisis center, a state-operated facility, an out-of-state placement, a general acute hospital, or an institution for mental disease (W&I Code §4698(a)(1)).
Containment	A brief physical (manual) restraint of an individual for the purpose of effectively gaining quick control of an individual who is aggressive or agitated or who is a danger to self or others. (H&S 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.

Definitions	
Delayed Egress	Delayed Egress (DE) devices are alerts on egress points on gates or doors that temporarily preclude the use of exits for a predetermined period of time. These devices shall not delay any resident's departure from the facility for longer than 30 seconds. Once the delay is released, direct support professionals may attempt to redirect an individual who attempts to leave the home, especially if the situation is unsafe. Must be DDS approved. (H&S Code 1531.1)
Direct Support Professional	An individual 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 provide 24-hour nonmedical care to individuals with developmental disabilities who require enhanced behavioral supports, staffing, and supervision in a homelike setting. (W&I Code §4684.80(a))
Emergency Intervention Plan	As per Title 22 §85322(a), an Emergency Intervention Plan is a written plan that must 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 CCH applicant or licensee in conjunction with a Behavior Management Consultant and must be part of the CCH 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 within 7 days of placement.
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.

Definitions	
Individual Behavior Supports Team	A team of individuals that includes, at minimum, the individual, the CCH administrator, QBMP with the authorized representative, regional center representative, and clients' rights advocate, as appropriate to develop, monitor and revise IBSPs. 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 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 set of research-based strategies used to increase quality of life and decrease problem behavior by teaching new skills and making changes in an individual'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 an individual's capabilities and keeping the individual'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, views an individual and their loved ones as the experts, and equally emphasizes satisfaction with quality of life and satisfaction with health/safety status.

Definitions	
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 H&S Code §1180.1(d) it is "the use of a manual hold to restrict freedom of movement of all or part of an individual's body, or to restrict normal access to the individual's body, and that is used as a behavioral restraint.
Delayed Egress/Secure Perimeter	Delayed Egress/Secured Perimeter homes are built with higher fences and delayed egress gates and/or gates for individuals with high elopement or impulse control risks. Secured perimeter homes fence perimeter and height must meet requirements of California Building Codes (CBC) and California Fire Codes (CFC) and follow local city and county codes. Must be DDS approved.
Target Behaviors	Specific behaviors exhibited by an individual that they or their IBST has identified for modification or reduction. Target behaviors could include, but are not limited to, harm to self, others, or property.

Bibliography/Resources

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Association for Positive Behavior Supports – http://www.apbs.org

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