Behavior Support Management in Therapeutic Schools, Therapeutic Programs and Outdoor Behavioral Health Programs

Addendum to the *NATSAP Principles of Good Practice*

June, 2004

The following Guidelines and Practice of Behavioral Management have been unanimously adopted by the Board of Directors of the National Association of Therapeutic Schools and Programs as basic practice standards ascribed to by member therapeutic programs and schools.

Guidelines and Practice of Behavioral Management

1.0 Introduction

When dealing with at-risk, troubled, oppositional, acting out, maladaptive and/or defiant youth, the program staff might be required to employ behavior support management techniques to foster adaptive, appropriate and pro-social behavior and assure the safety of the individual youth, other program participants and/or the staff. Such techniques start with the establishment of written guidelines, rules and expectations of appropriate and pro-social behavior. When a program participant's behavior is in opposition the written rules and guidelines and places him/herself and/or others in harms way, additional behavior management techniques may be utilized. Those behavior support management techniques range from verbal persuasion to physical interventions.

Hence, a school or program concerned with the safety of its program participants must advocate and practice a policy of behavioral support management that should:

1.1 practice behavior support management techniques designed to foster pro-social behavior. Such techniques are utilized not exclusively for the purpose of behavioral control. Behavioral support techniques include respondent and operant

conditioning, shaping, extinction, redirection and social modeling with both primary and secondary reinforcement integrated within the programming. Such techniques can be used appropriately to reduce excessive negative behavior and promote pro-social behavior and development;

1.2 employ the least intrusive method possible to assure the safety of all parties concerned (i.e. the individual child, other program participants and staff);

1.3 when possible, assure that less intrusive interventions have been offered to the child before more restrictive methods are applied;

1.4 when faced with the necessity of applying such interventions, protect as much as possible, the dignity and privacy of the program participant.

2.0 The Continuum of Behavior Management Techniques

Fundamentally, the continuum of behavioral support management techniques and interventions can be divided into three general categories: 1) behavioral management interventions that foster adaptive and pro-social behavior; 2) de-escalation procedures when the child becomes agitated (see 4.0); and 3) special treatment procedures when the program participant's intensity and duration is such that de-escalation techniques, including brief physical holdings, are no longer effective to bring the behavior under control (see 5.0).

3.0 Behavior Support Management Techniques Designed to Foster Pro-Social Behavior

Behavior support management techniques are therapeutic interventions utilized to foster pro-social and discourage maladaptive behavior within the program participants.

A school or program employing behavior support techniques should:

3.1 develop and implement written policies that govern the use of behavior support techniques;

3.2 fully inform program participants and his/her family regarding the behavior support system at the time of admission. (i.e. level system, pre-determined consequences for certain adaptive and maladaptive behaviors);

3.3 group consequences must be approached with great care and an effort not to infringe on individual's appropriate care. A written policy should describe the appropriate use of group consequences and describe limits on such consequence;

3.4 specify procedures and interventions that are prohibited. At a minimum, the following are prohibited:

3.4.1 procedures that deny a nutritionally adequate diet.

3.4.2 physically abusive punishment.

3.4.3 any behavior support intervention that is implemented by another program participant without the expressed consent of a staff member

3.4.4 any behavior support management intervention that is contrary to local, state and/or national licensing or accrediting bodies, should school or program be so licensed and/or accredited.

3.4.5 application of consequences that are not in accordance with the program participant's rights.

4.0 De-Escalation Interventions

De-escalation techniques are a part of the organization's overall behavior support policy and procedures, but are specifically delineated as those interventions that are designed to de-escalate agitated behavior that, if unchecked by the staff and/or the program participant, may rise to the level of being a danger to self, others, destruction of property or serious disruption of the therapeutic environment. Hence, the purpose of de-escalation interventions is to reduce maladaptive and agitated behavior and replace it with pro-social behavior. The skilled practice and application of de-escalation techniques are the most effective way to prevent the use of special treatment procedure.

De-escalation Technique should include Verbal Interventions (Example: Extensive training on the following topics should be in place.

a) Staff members need to mentally prepare. Remain calm, become aware of what the person is saying and doing, feel respect for person not the behavior.

b) Share your observations and listen to what is being processed.

c) Identify what is causing the issue and/or feeling.

d) Assist the person with developing more productive avenues to express feeling.

A school or program, employing de-escalation interventions, should incorporate the following elements into their behavioral support plan:

4.1 Whenever appropriate, least restrictive behavioral de-escalation interventions should be used.

4.2 Policy and procedure protocols delineate the a) type of behavior interventions utilized, b) what contextual circumstances call for what type of behavioral interventions and c) the duration and methods employed in the de-escalation process.

Examples for the use of least restrictive to most restrictive intervention could be:

- *Category I interventions might include teaching interventions, benign response reduction techniques such as verbal directives, prompts, redirection, contingent observation.*

- *Category II interventions might include over-correction, quiet time, time-out, and positive practice. Category III interventions might include novel, non-standard or experimental interventions.*

4.3 Policies and procedure govern the use of time-out.

4.3.1 The time-out protocols should distinguish between a self-directed time-out and a staff-directed time-out. Timeout should also be included in a tiered approach.

Examples of Time-Out Procedures:

1. *A program participant, returning from a group therapy session, is visibly agitated and is requesting a time-out. The individual is placed in an open-door time-out room and instructed that he may return to the regular, scheduled activity when he feels that he has regained adequate behavior and emotional control. After the program participant is requesting to re-join the regular activity, the staff assesses the program participant whether or not the program participant has sufficiently de-escalated to return to the regular group activity. Should the program participant not be ready, the staff directs the program participant to take additional time to regain control and composure.*

2. *Prior to a group therapy session, a program participant is requesting a self-directed time-out. The program participant has a pattern of avoiding group therapy because she does not want to be exposed to her peers' feedback about her behavior. The staff denied the program participant request for a self-directed time-out because it is clinically contraindicated and encouraged the program participant to attend the group.*

3. *A program participant is demonstrating agitated behavior, but is not requesting a self-directed time-out. As part of a progressive de-escalation protocol, the staff is directing the program participant to*

take a time-out in the open-door time out room. The staff member stands in the open door to prevent the individual from leaving the time-out room. Periodically, the staff will assess the individual as to whether or not he has gained sufficient behavioral control to return to the regularly scheduled activity. If the staff decides, following an assessment of the program participant, that he should not rejoin the regular scheduled activity and prevents him from leaving the time-out room by physically blocking the exit for more than 30 minutes, the time-out procedure has risen to the level of a special treatment procedure.

4.4 Policies and procedure should govern the use of brief physical holding interventions.

4.4.1 Brief physical holdings may only be utilized under the following conditions:

4.4.1.1 Danger to self (i.e. attempting to or in the process of head banging, punching the wall, attempting to swallow a "sharp," scratching or carving in an attempt to cause damage, etc.).

4.4.1.2 Danger to others (i.e. attempting to or endangering others by slapping, kicking, biting, etc.).

4.4.1.3 Substantial destruction of facility/staff/others property (i.e. damaging furniture, computer equipment, etc.).

NOTE: Programs should check with their individual licensing agency when considering the above examples.

4.4.2 Therapeutic holds should not exceed 30 minutes. If a program participant, placed in a therapeutic hold, is unable to regain control within 30 minutes and the procedure needs to be extended beyond the 30 minutes, the therapeutic hold then rises to the level of a special treatment procedure.

Examples:

a) An individual is shouting obscenities at his peers. The peers are visibly agitated. The individual is not responding to verbal request from the staff. The individual is offered a staff directed time-out. The individual refuses to walk to the time-out area but escalates with obscenity and threats of violence. The Staff attempt to physically escort the individual to the time out area. In the process, the individual is punching a staff member. As a result, the

individual is placed in a therapeutic hold. Within 10 minutes, the individual is calm and released from the therapeutic hold – this is not a special treatment procedure.

b) *Should the child require a therapeutic hold for more than 30 minutes in order to regain control, the therapeutic hold will rise to the level of a special treatment procedure.*

4.5 Brief physical holds are never used as punishment.

4.6 Therapeutic holds are documented in the program participant's treatment record.

5.0 Special Treatment Procedures (STP)

Special Treatment Procedures refer to a specific class of behavioral interventions that restrict the free movement of a child by mechanical or physical means for a prolonged period of time when the child becomes a danger to self and/or others, is destructive of property, or is a serious disruption to the therapeutic environment. Specifically, those interventions are referred to as seclusion, restraint, or more than 30 minutes of a physical hold.

Seclusion is a procedure where the individual is restricted to a small space, such as a time-out room, without the ability to leave the room, i.e. the individual is blocked from exiting either by a locked-door or by a staff standing in the door and preventing the program participant from leaving the room for more than 30 minutes.
A Restraint procedure occurs when a mechanical device such as leather belts, posy belts, strait jackets, hand cuffs, or other devices are used to restrict the free movement of an individual or whenever a program participant is placed in a physical hold exceeding 30 minutes.

Those NATSAP members, who employ special treatment procedures, must be licensed or accredited by state and/or national regulatory organizations that specifically address the use of said procedures.

However, any NATSAP member program may resort to physical restraint in order to remove a participant to a more restrictive level of care in the event of imminent threat of serious injury to the program participant or others. All NATSAP programs must have specific policy, procedures, and training to respond to such emergent situations.

6.0 Risk Management and Performance Improvement

6.1 *Physical holdings, restraint and seclusion can be high risk and problem prone.* The organization should collect data on the use of brief physical holding

interventions and special treatment procedures in order to monitor and improve performance of processes that involve risk or may result in sentinel events.

7.0 Informed Consent

7.1 Parents/guardians and students/residents are informed, at the time of admission regarding behavior management interventions including physical holding and special treatment procedures.

Elements of Guideline:

- *Upon admission, the family and program participant are informed about the general conditions under which behavior management techniques are utilized, including physical holdings, seclusion and/or restraint. A written consent is obtained for the parent/guardian, and if applicable, by the program participant for the use of these interventions.*

- *As part of the admission process, the staff presents the parent/guardian with a written, general explanation of behavior management policies and procedures, including the use of physical holdings, seclusion and/or restraint.*

- *Parent/Guardian signature(s) are obtained for the use of those interventions. Students/residents are equally informed about these interventions and are encouraged to sign the consent form. They may refuse to sign the form but parental/guardian written consent will permit the application of those interventions.*

8.0 Staff Training and Competence

8.1 Staff is trained and competent in the use of the behavior support policy and procedures.

8.2 Staff is trained and competent to minimize the use of intrusive behavior intervention such as physical holdings, seclusion and/or restraint.

Elements of Guideline:

a) The organization educates, assesses and documents the competence of staff in minimizing the appropriate use of physical holdings, seclusion and/or restraint and, before they participate in any use of said interventions, are also educated and trained in their safe use.

b) *In order to minimize the use of these procedures, all direct care staff as well as any other staff involved in the use of said interventions receive ongoing training in and demonstrate an understanding:*

- *of the underlying causes of threatening behaviors exhibited by the program participants;*

- *of the possibility that a program participant may exhibit an aggressive behavior that is related to a medical condition and not related to his or her emotional condition, for example, threatening behavior that may result from delirium in fever and hypoglycemia;*

- *of how a staff's own behaviors can affect the behaviors of the program participant;*

- *of the use of de-escalation, mediation, self-protection and other techniques, such as time-out,*

- *recognizing signs of physical distress in individuals who are being held, restrained, or secluded.*

c) *Staff charged with monitoring or initiating the holdings, seclusion and/or restraint procedure receive the training and demonstrate the competence to assess the program participant throughout these procedures.*

Glossary of Terms

Brief Physical Holding: A non-violent physical intervention restricting the movement of a youth, or restricting the movement of normal function of a portion of the youth's body as described in agency-approved training methods, by forcefully and involuntarily depriving the youth of free liberty to move about. Simple physical redirection which does not cause pain, such as hand on the back or briefly holding the upper arm or clasping of the hand, should not be considered a physical restraint. Brief Physical Holdings may not exceed 30 minutes in duration. If a program participant requires holding for more than 30 minutes, said procedure has risen to the level of a Special Treatment Procedure.

Special Treatment Procedure: A specific class of behavior interventions restrict the free movement of a child by mechanical or physical means for a prolonged period of time, and/or a physical holding that exceeds 30 minutes in duration in response to threats or actions of self harm, harm towards others, destruction of property, and serious disruption of the therapeutic environment. Specifically, those interventions are referred

to as seclusion and mechanical restraint and/or physical holdings for more than 30 minutes in duration.

Seclusion: A procedure where the individual is restricted to a small space, such as a time-out room, without the ability to leave the room, i.e. the individual is blocked from exiting either by a lock-door or by a staff-restricting exit for more than 30 minutes. That is to say, that a procedure where the individual is prevented from exiting a confined space for 29 or less minutes, is not a seclusion procedure.

Mechanical restraint: A procedure where a mechanical device such as leather belts, posy belts, strait jacket, hand cuffs, and other devices are used to restrict the free movement of an individual. Therapeutic holds (see 4.4) that are longer then 30 minutes in duration, are also considered restraint procedures.

Time-Out: Time-out procedures are those classes of interventions in which the program participant is offered a time away from the regular scheduled activity in order to gather himself and/or re-establishing the locus of control within him/her, in an attempt to de-escalate agitated behavior and/or to prevent a serious disruption of the therapeutic environment. When possible, time-out interventions are conducted away from stimuli that may contribute to the escalation of maladaptive behavior and/or reduce the probability for serious disruption to the therapeutic environment. Time outs in excess of 30 minutes should be classified as seclusion.

Self Directed Time-Out: A procedure where the program participant is requesting a time-out in effort of regain control and/or composure, sensing or knowing that he/she is agitated and desiring some time to de-escalate. The program participant should be given adequate time to do so. At any time during a self-directed time-out, when it becomes evident that the continuation of the self-directed time-out becomes clinically contraindicated, the procedure is terminated by the staff.

Staff Directed Time-Out: A time-out procedure where the program participant is restricted, for 30 minutes or less, from leaving an unlocked room or area. A procedure where the individual is restricted for 30 minutes or *more* in the time-out area is a special treatment procedure (see definition). A staff directed time-out procedure may not deny the program participant from daily, adequate nutritional intake and deprive him/her from regular eliminating.

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