

**Reducing the Use of Restraint  
and Seclusion of Individuals  
with Traumatic Brain Injuries**

Webcast:  
By the Health Resources and Services  
Administration's  
Federal TBI Program Web Cast  
July 27, 2006  
2:00-3:30 p.m.

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Moderator:  
**Kenneth Shiotani**

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## Purpose

- To outline the issues and concerns involving the use of restraint and seclusion of individuals with TBI
- To identify strategies for reducing the use of R&S of individuals with TBI

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## Speakers

- Harvey E. Jacobs, Ph.D., Licensed Clinical Psychologist / Behavior Analyst
- Marty McMorrow, Director of National Business Dev., The MENTOR Network
- Jane Hudson, J.D., Senior Staff Attorney, National Disability Rights Network

(Contact Info in Handout)

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## Definition of "Restraint"

- Physical restraint - mechanical or personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs or head freely, or
- Drug or medication used to control behavior or restrict the resident's freedom of movement, not standard treatment for resident's medical or psychiatric condition

*Children's Health Act of 2000, 42 U.S.C. § 290ii(d)(1)*

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## Definition of "Seclusion"

- A behavior control technique involving locked isolation
- Not time-out
  - Behavior management technique
  - Part of approved treatment program
  - Separation of resident from group
  - In a non-locked setting
  - For purpose of calming

Children's Health Act of 2000, 42 U.S.C. § 290ii(d)(2) and(3)

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## TBI Statistics

- 1.5 million emergency room visits annually
- 80,000-90,000 severely and permanently disabled *annually*
- Another 225,000 annually experience mild to moderate disability that affects behavior, emotions, health and personal productivity

Centers for Disease Control

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## More TBI Statistics

- At least 5.3 million Americans (~2% of the U.S. population) currently live with disabilities resulting from traumatic brain injury.
- Double the above findings when all forms of acquired brain injury are considered

Centers for Disease Control

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### Behavioral Statistics

- Approximately 90 % of all people who experience severe disability following brain injury experience some emotional or psychiatric distress.
- 40% continue to demonstrate behavioral difficulty five years following their initial injury.

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### More Behavior Statistics

- 25% experience behavior dysfunction that interferes with other activities of daily life.
- 3% - 10% experience severe behavioral dysfunction that may require intensive professional and residential intervention (~3,000 – 9,000 new people per year).

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### Behavioral Challenges

Residuals that may contribute to behavioral challenges if not properly recognized:

- Memory
- Orientation
- Attention / Concentration
- Communication / Comprehension
- Perceptual Challenges ...

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### Behavioral Challenges (con't.)

- Judgment / Reasoning
- Problem-Solving Skills
- Stamina / Fatigue
- Physical / medical co-morbidities

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### More Behavioral Challenges

Behavioral challenges can also occur due to factors such as:

- Disinhibition
- Impulse Control
- Inhibition
- Lack of self or social awareness

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### More Behavioral Challenges (con't.)

- Inability to acknowledge difficulties
- Frustration / Anger Management
- Changes in roles and identities
- Loss of goals
- Changes in others
- Lack of resources

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### Can Result in....

Almost all people who experience disability following brain injury are not inherently aggressive or assaultive. However, for some people, when challenges are not properly addressed this can result in:

- lack of responsiveness to requests
- property destruction
- verbal or physical aggression
- violation of personal or sexual boundaries
- wandering or flight
- self harm/self abuse/suicide

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### But...

The brain injury is not the sole *cause* of these behaviors. It is a combination of changes in the way a person experiences and relates to the world following a brain injury

-- AND --

How the world relates to the person!

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### “Neurobehavioral Challenges”

Most “neurobehavioral challenges” are caused by:

- Pre-injury history
- Post-injury learning and experiences
- Inability to negotiate “difficult” situations
- Others’ not recognizing the basic challenges to an individual with TBI, and
- not providing proper treatment.

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### Course of Treatment for Individuals with TBI

There is no one course of treatment for people following brain injury.

Some enter services through the emergency room and into the hospital

Some only receive services at the emergency room

Some only receive services from a physician or psychologist

Some never receive services, proper assessment, or even realize that they have a brain injury

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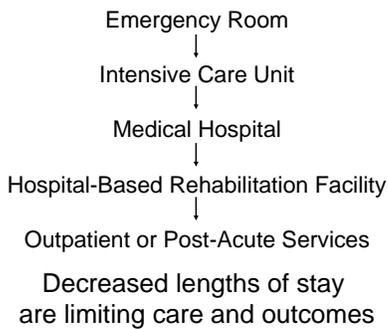
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### A Continuum of Care Following Severe TBI




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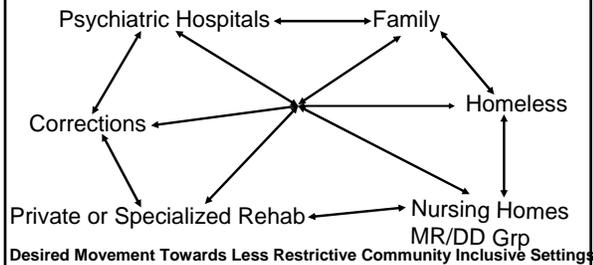
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### Post-Hospital Course for Many Individuals with TBI

People may end up in many different venues at many different times




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## Goals

- Less Restrictive
- Community Inclusive Settings
- Independence
- Choice and Self-determination
- Positive Behavior Supports, instead of S&R

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At least 95% of all people  
who sustain a brain  
injury do not get the  
long-term services  
and supports they need

Brain Injury Association of America

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## “Albert”

- Small-sized adolescent, smart
- In and out of adolescent psych hospitals  
for years with history of bipolar disorder
- Behavioral issues...

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### “Albert” (cont.)

- Multiple episodes of seclusion and restraint
- Locked seclusion room, staff looking through door window
- Staff members holding him face down several times per day

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### “Randy”

Continually kicked out of group homes due to safety problems:

- fires in kitchen
- running away
- non-compliance

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### “Vicki”

33 yr. old

- 1 year post injury/Non-ambulatory
- Had no rehab/Placed in SNF
- Intensely confused and agitated
- Loud, verbally and physically aggressive when others were close by ...

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**“Vicki” (cont.)**

- 4 pt spread eagle restraint daily for long times
- Passive seclusion in name of low-stimulation
- Post Injury Trauma?

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**“Bill”**

- Nicknamed “Wild Bill” by caregivers in “rehab” facility
- One-year post injury/Confused/Non-ambulatory
- Aggressive Behavior
- “Seizure-like” behavior
- Gross Polypharmacy...

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**“Bill” (cont.)**

- Low Stimulation environment
- Enclosed bed, padded trails, posey chair
- Staff and family reluctant to make changes b/c they thought he was doing the best he could considering injury

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### Traditional Approaches to Management of Behavioral Issues

- Designed to protect individual from harm to self or others
- Principal focus on reduction of potentially “dangerous behaviors”
- Often result in techniques that incorporate behavioral suppression via “behavior management” or behavior modification

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Although progress has been made... “Behavior management/modification” often means:

- Restraint
- Exclusion/Seclusion
- Medication for behavioral control (a.k.a. chemical restraint)
- Coercive practices/loss of independence options
- Insufficiently developed “reinforcement” programs that focus on reduction of undesirable behaviors

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### Traditional Staffing

- Hospital-based rehabilitation and psychiatric treatment environments rarely include individuals with specific behavioral or brain injury expertise on team
- Staff rarely trained in techniques of behavior analysis or positive supports as the primary modes of intervention
- Staffing ratios and deployment are rarely sufficient for individual needs

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### Traditional Focus

- Often focus on symptom management instead of skill development approaches
- Therefore, often strong emphasis on doing what is necessary to stop the undesirable behavior rather than finding root causes and addressing them
- Fail to understand that “aberrant” behavior is a reaction or response to aberrant or difficult situations

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### Traditional Environmental Design

- “iatrogenic” (induced in an individual by a caregiver’s activity, manner, therapy or program design)
- Actually promulgates problem behaviors that staff are trying to stop

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### Traditional Environmental Design

Includes:

- Crowded areas
- Poorly designed or described daily activity patterns for clients/patients
- Expectation that persons will be responsive to verbal requests
- Incomplete and poorly trained staff

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**Behavioral/Interactive Approaches  
that may reduce S&R**

- Establishing commitments or stands re: eliminating restrictive interventions
- Basic competency and accountability for staff and administration in effective programs
- Distinguishing between “behavior management / modification” and behavior analysis

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**Behavioral/Interactive Approaches  
that may reduce S&R**

- Emphasis on positive behavior supports and pro-social skill development based on a person's strengths.
- Environmental design considerations
- Creating staff training and expectations re: proactive interactional behavior
- Basic accountability for evaluating treatment efficacy (e.g., an outcome orientation)

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**Behavioral/Interactive Approaches  
that may reduce R&S**

- Involving the consumer in all aspects of treatment planning, operation and evaluation.
- Specific de-escalation techniques
  - Redirection
  - Interspersed requests
  - Behavioral momentum
  - Functional replacement training
  - Reinforcer Recall
  - Encouraging Outcomes

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Approaches to Behavior Change

	ONE WAY	ANOTHER WAY
Focus	Single Behavior	Complex Sequence
Goal	Reduce Inappropriate	Increase Appropriate
Style	Reactive	Proactive
Timing	Consequence (After)	Antecedent (Before)
Intent	Provider Control	Personal Control
Locale	Excluded Site	Included Site
Purpose	Manage Behavior	Empower Participant
Flavor	Impersonal	Mutually Reinforcing

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Sample Statistics from Contemporary NBR Rehab

- A nationally recognized neurobehavioral program with an average census of 30 had ~1200-1500 “episodes” of physical aggression each year over a 5 year period
- Lack of responsiveness to requests, verbal threats, property destruction, and physical aggression were most frequent among a list of 20 “unwanted” behaviors

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Sample Statistics from Contemporary NBR Rehab (cont)

- Chemical restraint, mechanical restraint, seclusion, and exclusionary time out were virtually unused
- Among this group, physical interruptions (X = 2.3 min. per hold) averaged less than 3.5 per month, whereas manual restraint (X = 12.6 min. per hold) averaged 6.2 per month (< 10% of all episodes of potentially dangerous aggressive behavior)

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What can advocates do to reduce S&R of individuals with TBI?

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### Develop multi-faceted plan

Step 1: Establish S&R reduction at particular facility as a priority.

Step 2: Get Commitment of Leadership and Training of Facility Staff

Step 3: Train consumers to be self-advocates to reduce S&R.

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### Multi-Faceted Advocacy Plan

Step 4: Get primary funding/accrediting agencies to investigate violations.

Step 5: Advocate for state S&R legislation.

Step 6: Litigate and use media to draw attention to issue if other strategies fail.

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Step 1:  
Establish S&R reduction priority

- P&As establish priorities every year
- Get residents of institutions on P&A advisory councils and boards
- Research: Is S&R overused/misused in particular institution?
- If so, establish priority to reduce S&R in that institution

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Step 2:  
Leadership/ Staff Training

Key factors in reduction of S&R:

- Committed Leadership at the Top
- Cultural Change in Staff
- Ongoing staff training
- Resources:

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Training Resources

- “Roadmap to Seclusion and Restraint Free Mental Health Services” published by Center for Mental Health Services (2006)
- National Ass’n of State Mental Health Program Directors (NASMHPD)
  - Assumptions and Neuro/Bio/Psycho Effects
  - Trauma-Informed Care
  - Leadership/Workforce Development
  - Risk Factors/Prevention Tools

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## Various for-profit companies

- Find out what training program provider is using
- Research that company and others
- Attend training
  - Know what is being taught
  - Use training materials as advocacy tool (facility not following training recommendations)

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### Step 3:

#### Training for Self-Advocacy

- P&As have Congressional mandate to provide information, referral and training
  - Put up posters in institution re S&R rights
  - Conduct rights training for residents
  - Conduct joint trainings for residents/staff
  - Developing safety plans
  - Debriefing
  - Development of Comfort Rooms

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### Step 4:

#### Primary investigation agencies

- Federal Medicaid/Medicare funding dependent on facility compliance with federal S&R laws
- Consumers and advocates can file complaint with State agency
- Investigation, deficiencies, oppt to correct
- Ultimate penalty...termination of funding, but rare

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**Basic rights  
Medicaid/Medicare Facilities**

- Not for discipline or convenience
- Only to ensure physical safety of resident, staff member or others, and
- Only upon written order of a physician or other licensed practitioner permitted by state to order S&R (specifying duration & circumstances)

CHA (H), 42 U.S.C. § 290ii(a) and (b)

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**Conditions of Participation  
(Regulations)**

- After CHA enacted in 2000, CMS has only issued CoPs for psychiatric residential treatment facilities for individuals under age 21(PRTFs)
- CMS has not revised existing S&R CoPs for:
  - hospitals, 42 CFR § 482.13
  - intermediate care facilities for individuals with mental retardation, 42 CFR § 483.420
  - long-term care facilities, 42 CFR § 483.13.

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**Conditions of Participation**

- CoPs may cover:
  - Definitions
  - Prohibitions on certain types of R&S
  - Orders and prohibitions on standing orders
  - Time limits and renewals
  - Monitoring and Debriefing
  - Reporting
  - Training

(Handout prepared by Advocacy, Inc)

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**Step 5 (cont)**  
**Accreditation Agencies**

- Joint Commission on Accreditation of Healthcare Organizations Standards (JCAHO) for Behavioral Health Care
- Restraint and Seclusion Standards (Provision of Care Standards 12.10-12-190) (NDRN has copy of standards)
- File complaint with JCAHO  
<http://www.jointcommission.org/GeneralPublic/Complaint/>

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**Step 5:**  
**Legislative Action**

- P&As working with other advocates to get state S&R laws enacted (schools, too!)
- 14 Elements of Good Restraint Law, by Bob Fleischner of Center for Public Representation (June 2006)

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**Step 6:**  
**Litigation**

- P&As have the statutory authority to pursue administrative and legal remedies to protect individuals with disabilities.
- Wrongful death or personal injury actions for damages from R&S
- Injunctions to force facilities to have policies and training

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**Step 6 (continued)**  
**Media Strategies**

- Hartford Courant series about 142 deaths resulting from restraints over 10 year period
- Media focus – Helped spur Congress to enact S&R provisions of Childrens’ Health Act
- Advocates have worked with media to alert public to R&S abuses

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**Summary**

- 1) Develop S&R priority
- 2) Advocate for leadership commitment and staff training
- 3) Train self-advocates
- 4) Get primary agencies to investigate.
- 5) Advocate for state S&R legislation.
- 6) Use litigation and media strategies.

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**Application of Behavioral/Interactive Approaches and Law to Scenarios**

**“Albert”**

Repeated placement in psychiatric hospitals for bipolar disorder

- Careful review of history > untreated brain injury at age 4
- When treatment altered to address diagnosis he was able to leave revolving door of “treatment” and return to home, community and public school.

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### Advocacy for “Albert”

- Assist him in getting proper diagnosis, safety planning, debriefings and discharge to appropriate settings
- File complaint about violations of federal and state S&R rules
- Train staff about dangers of prone restraint and positive behavior supports
- Outreach, training and advocacy to other residents who are being S&R
- Connect him with peer support network

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### Application of Behavioral/Interactive Approaches and Law to Scenarios

“Randy”

*Non-compliance*

Further evaluation.... Problems due to difficulties with attention / concentration, memory and comprehension

#### Solutions:

- Provide information in smaller packets
- Use rehearsal strategies to assure that he understands
- Increase the use of checklists and pictures to provide backup

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“Randy”

*Fire Setting*

- Randy forgot what he was doing and left pans on stove. Staff tried to correct by explaining proper steps for cooking and safety, but Randy forgot them.
- Solution:
  - Writing down rules
  - Using pictures of safe practices
  - Better monitoring
  - Teach microwave use as a back-up

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## “Randy”

### *Running Away*

- When Randy went for a walk, he got lost and could not find his way back.
- Solution:
  - Writing down rules
  - Better monitoring
  - Picture maps of neighborhood
- Result: Randy did not have to go into a more restricted level of care/living.

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## Advocacy for “Randy”

- Bring in others to assist Randy and staff to better understand his capabilities and limitations
- Get Randy’s ideas about how he can avoid fires and getting lost
- Advocate for safety plan
- Connect him with peer support network
- Assist him re larger community integration issues

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## Application of Behavioral/Interactive Approaches and Law to Scenarios

“Vicki” (confused, agitated, aggressive)

- Successful use of Functional Replacement
- Did not receive public funding for neurobehavioral rehab
- Whereabouts not known

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### Advocacy for “Vicki”

- File complaint re violations of Children's' Health Act: Physical safety? Discipline? Convenience? Written order?
- Advocate for specific S&R regs for long-term care (LTC) facilities...also state laws?
- Advocate for trauma informed care
- Advocate for staff training on alternatives to S&R
- Connect her with peer support network

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### Application of Behavioral/Interactive Approaches and Law to Scenarios

“Bill” (confused, aggressive, seizure-like behavior)

- immediately reduced medications from 23 to 1 within a month
- treated on homelike “dormitory style” unit with no restrictive procedures, but lots of staff supports
- began to walk independently and speak clearly

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### “Bill” (cont.)

- Taught fundamentals of self-management
- Discharged from specialized NBR program within 4 months, moved home with family after 7 months
- Returned to work until early retirement/divorced
- Sends letters and Christmas cards regularly

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### Advocacy for "Bill"

- Advocate for medication re-evaluation
- File complaint re: violations of federal and state S&R laws
- Advocate for community integration with supports
- Teach Bill about his rights re: physical and chemical restraints
- Help Bill develop safety plan
- Assist Bill in "debriefings"
- Connect him with peer support network

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### Concluding Remarks

- Distinguish between behavior analysis and "behavior modification / management"
- Determine whether behavioral issues may be result of a brain injury via comprehensive assessment
- Emphasize consumer involvement in services
- Identify appropriate skill development strategies

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### Concluding Remarks (cont)

- Emphasize productive activity patterns
- Emphasize positive behavioral supports
- Emphasize competencies of caregivers
- Modify environment
- Use multi-faceted advocacy approach
- Resources, resources, resources!!!!!!!

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