

NATIONAL EVALUATION QUARTERLY REPORT CARD

BEST PRACTICES IN BEHAVIOR SUPPORT AND INTERVENTION

CHILD WELFARE LEAGUE OF AMERICA

Vol. 2. No. 1 OCTOBER 2003

Inside This Issue:

- **Page 1:** Introduction
- **Pages 2-6:** Evaluation Outcomes
- **Page 6:** Project Activities
- **Page 7:** Credits and Come Visit Us Online!

CURRENT OUTCOMES

- Overall, reductions in the use of physical restraint, mechanical restraint, and seclusion continue to be the trend, despite increases in each emergency physical intervention type during this quarter.
- Children under twelve are over-represented in the use of emergency physical interventions, especially in regard to physical restraint.
- Physical interventions occur most often when staff members are assaulted or property is damaged.
- Staff members are injured during restraint or seclusion almost twice as often as children.

The Child Welfare League of America (CWLA), in collaboration with the Federation of Families for Children's Mental Health (FFCMH), serves as the Coordinating Center for the three-year Best Practices in Behavior Support and Intervention Project. The project is designed to reduce the use of restraint and seclusion in seven demonstration sites across the country by improving the training and supervision of staff that work with children and youth.

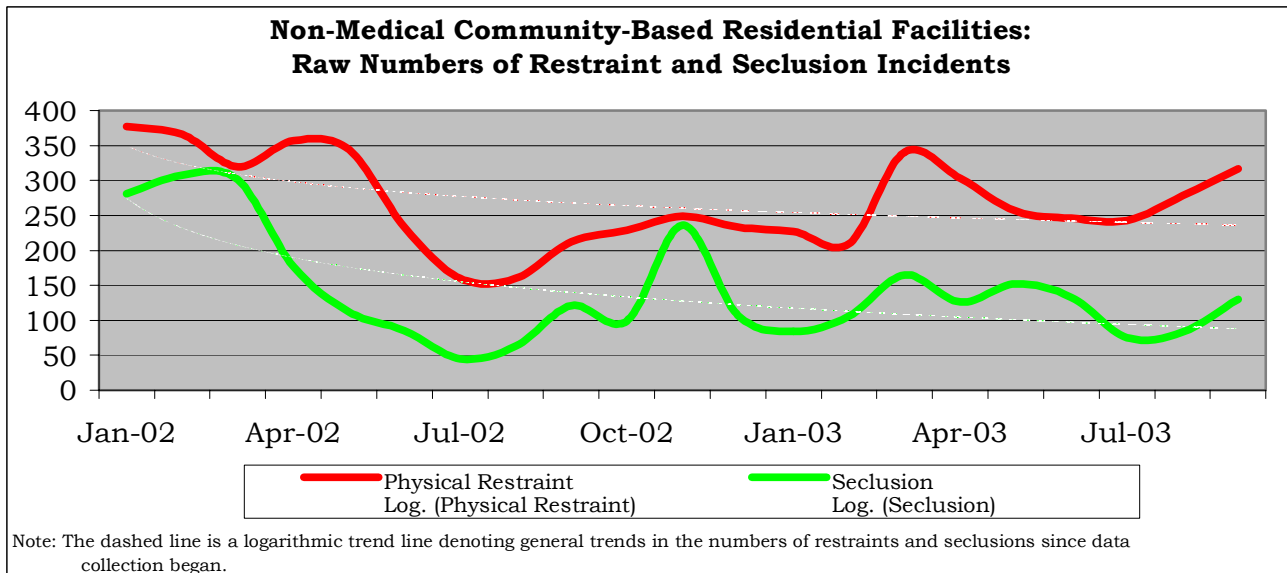
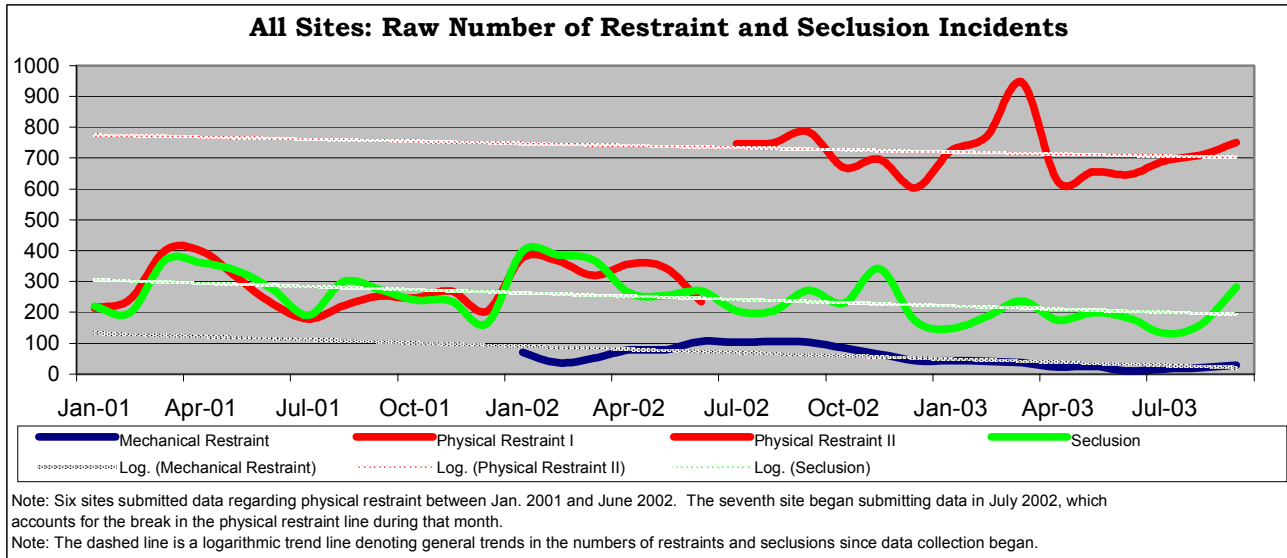
The project is administered by CWLA's Walker Trieschman National Center for Professional Development. The funding for the project is provided by the Substance Abuse and Mental Health Services Administration (SAMHSA). The project timeline stretches from October 1, 2001 to September 30, 2004.

The project has continued to evolve as the knowledge base regarding behavior support and intervention has grown. In September 2003, the project's title changed from the "Best Practices in Behavior Management Project" to "Best Practices in Behavior Support and Intervention Project." The new title emerged in part because of strong recommendations from the field, which felt it was critical that organizations begin re-framing incidents of restraint and seclusion in order to achieve reductions in their use. The change also reflects CWLA's belief that for behavior to be truly managed, an individual must manage that behavior him or herself. It is the caregivers' job to be supportive as children and youth learn to regulate their own behavior, and in the rare case where children's behavior puts themselves or others at imminent risk of harm, it is the caregivers' responsibility to intervene with the purpose of maintaining safety.

This is the fifth National Evaluation Report Card, which details the project's most recent findings. For the past two years, the Coordinating Center has been documenting the scope of restraint and seclusion use in an effort to inform practice. Creative interventions continue to be evaluated and best practices isolated.

Main goals and objectives

The Coordinating Center is responsible for three major tasks: providing technical assistance, evaluating the outcomes of the interventions implemented at each site, and disseminating results to promote best practices. The project draws on input from field experts, consumers, and family members to develop training models that effectively reduce the use of restraint and seclusion.



The first graph includes data from all seven sites participating in the Best Practices in Behavior Support and Intervention Project. The second includes data only from those sites categorized as non-medical, community-based residential facilities. Because each facility began by reducing the most restrictive procedures first, hospitals have focused on reducing mechanical restraint and seclusion, while non-medical facilities have been working towards reducing the use of seclusion and physical restraint. Between January 2002 and September 2003, 50% of all reported critical incidents¹ led to the use of physical restraint², 15%

led to the use of seclusion³, and 4% led to the use of mechanical restraint⁴.

¹ Three sites report all critical incidents (e.g. accidental injuries, theft, etc.), regardless of whether or not they lead to restraint and seclusion.

² For the purpose of this project, physical restraint is defined as the application of physical force by one or more individuals that reduces or restricts the ability of an individual to move his or her arms, legs, or head freely. Physical restraint does not include the temporary physical holding of an individual when used to assist the individual to participate in activities of daily living (ADL).

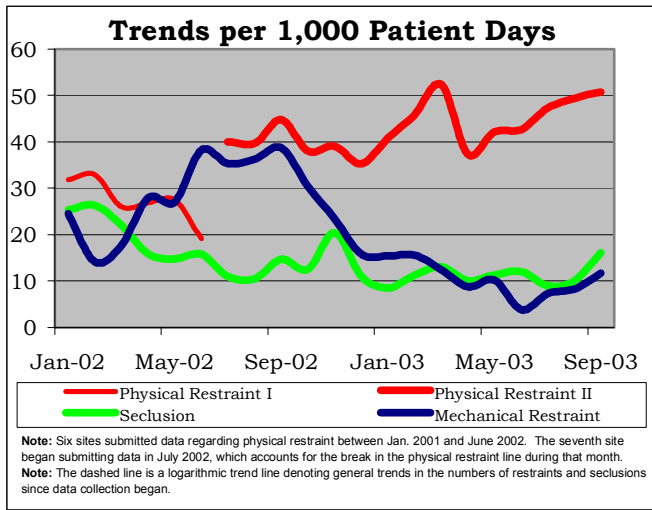
³ For the purpose of this project, seclusion is defined as the placement of an individual alone in any room from which the resident is physically prevented from voluntarily leaving.

⁴ For the purpose of this project, mechanical restraint is defined as the use of any physical device that reduces or restricts the ability of an individual to move his or her arms, legs, or head freely. Mechanical restraint does not include devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or any other methods that involve the physical holding of a resident for the purpose of conducting routine physical examination, tests, surgery, to protect the resident from falling out of bed or to permit the resident to participate in activities without the risk of physical harm to the resident.

Evaluation Outcomes

The project implementation period began in January 2002 and continued until May 2002. During that time, consultants began meeting with each site, and programs began implementing interventions. The evaluation period began in June 2002.

Restraint and Seclusion Incidents^{5,6}



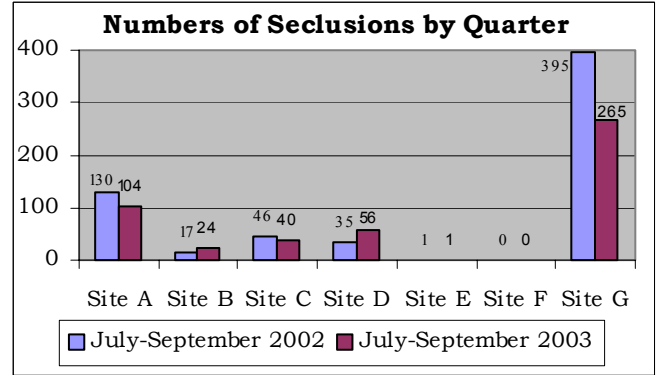
- ❖ **Mechanical Restraint:** Between January 2002 and September 2003, the average number of mechanical restraint incidents⁷ fell by 47% from 24.6 per 1,000 patient days to 11.6 incidents per 1,000 patient days.
- ❖ **Seclusion:** Between January 2002 and September 2003, the average number of seclusion incidents⁸ fell by 64%, from 25.3 per 1,000 patient days to 16.1 seclusion incidents per 1,000 patient days.

⁵ Without established overall target levels as a guide, the interpretation of rates must take into consideration the context within which sites operate and client base that sites serve.

⁶ Six sites submitted data regarding physical restraint between January 2001 and June 2002. The seventh site began submitting data in July 2002, leading to the large increases in restraints during that month.

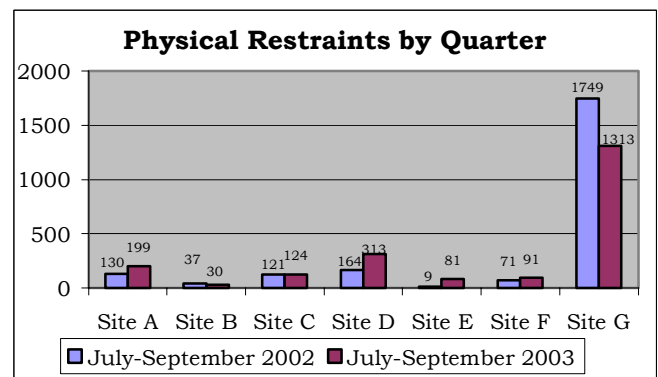
⁷ One site submitted data regarding mechanical restraint.

⁸ Seven sites submitted data regarding seclusion.



Comparing the number of seclusions that occurred between July and September 2002 with the same quarter in 2003 reveals a number of important trends. During that period, Site G experienced the most dramatic decrease in the use of seclusion, falling by almost 33%. Site A and Site C also experienced reductions in the use of seclusion by 20% and 40% respectively. Site D's use of seclusion increased by 60% and Site B's by 40%⁹. Sites E and F have eliminated the use of seclusion entirely.

- ❖ **Physical Restraint:** Between July 2002 and September 2003, the average number of physical restraint incidents¹⁰ increased by 26% from 40.3 per 1,000 patient days to 50.8 incidents per 1,000 patient days. Site G consistently had the highest number of physical restraint per 1,000 patient days, averaging 178.8 physical restraints per 1,000 patient days between July 2002 and September 2003. Sites B, E, and F averaged less than 10 incidents of restraint per 1,000 patient days.



⁹ Both increases are in part related to major organizational shifts, such as unionization efforts, that created substantial disruption of regular routines at the sites.

¹⁰ Seven sites submitted data regarding physical restraint.

Comparing the number of physical restraints that occurred between July and September 2002 with the same quarter during 2003 reveals a number of important trends. During that period, Site G experienced the largest decrease in the number of physical restraints, decreasing by nearly 25%. Site B also experienced reductions in the number of physical restraints by 19%. Sites A, D, and E experienced the largest increases in the use of physical restraint by 53%, 91% and 900%¹¹ respectively.

Demographics

❖ **Ethnicity:** Of the four sites that report child ethnicity, African American (37%), Caucasian (32.0%), and Hispanic (26%) children composed the majority of clients involved in incidents of restraint or seclusion.

Ethnicity of Client Involved in Restraint or Seclusion by Site: July-September 2003

		Ethnicity			
		African-American	Caucasian	Hispanic	Other
Site A	Physical Restraint	46%	37%	10%	8%
	Incident Involvement	44%	37%	10%	8%
	Population Demographic*	48%	42%	1%	10%
Site D	Physical Restraint	32%	42%	0%	25%
	Incident Involvement	36%	52%	2%	11%
	Population Demographic*	32%	55%	2%	11%
Site E	Physical Restraint	22%	76%	1%	0%
	Incident Involvement	na	na	na	na
	Population Demographic*	45%	50%	1%	5%
Site G	Physical Restraint	43%	17%	39%	0%
	Incident Involvement	42%	16%	42%	0%
	Population Demographic*	31%	35%	32%	2%

*Numbers reflect total population data for the period between July 2003 and September 2003
 **Numbers reflect the total population data for the period between March 2003 and June 2003

❖ **Gender:** Consistent with research, boys (65%) were involved in more restraint and seclusion incidents than girls.

¹¹ The large percentage increase in the use of physical restraint at Site E can be in part attributed to the exceptionally low numbers (n=9) of physical restraints that they experienced during the July-September quarter in 2002. The actual increase in raw numbers of physical restraints can be substantially attributed to leadership issues at a single cottage, which interfered with the implementation of the appropriate milieu.

Sex of Client Involved in Restraint or Seclusion by Site: July-September 2003

		Sex	
		Female	Male
Site A	Physical Restraint	40%	60%
	Incident Involvement	49%	51%
	Population Demographic*	30%	70%
Site D	Physical Restraint	28%	72%
	Incident Involvement	52%	48%
	Population Demographic*	50%	50%
Site E	Physical Restraint	11%	89%
	Incident Involvement	na	na
	Population Demographic*	58%	42%

*Numbers reflect total population data for the period between July 2003 and September 2003

Age: Fifty-nine percent of youth who experienced a restraint or seclusion were between the ages of 5-12.

Age of Client Involved in Restraint and Seclusion by Site: July-September 2003

		Age	
		0-12 years	13-22 years
Site A	Physical Restraint	99%	1%
	Incident Involvement	100%	0%
	Population Demographic*	67%	33%
Site D	Physical Restraint	0%	100%
	Incident Involvement	0%	100%
	Population Demographic*	12%***	88%
Site E	Physical Restraint	93%	7%
	Incident Involvement	na	na
	Population Demographic**	40%	60%
Site F	Physical Restraint	60%	40%
	Incident Involvement	na	na
	Population Demographic	not reported	not reported
Site G	Physical Restraint	54%	46%
	Incident Involvement	26%	74%
	Population Demographic*	28%	72%

*Numbers reflect total population data for the period between July and September 2003
 **Numbers reflect total population data for the period between March and June 2003.
 ***Site D does not admit children under age 12.

Critical Incidents that Do Not Involve Restraint or Seclusion

Sites D, F, and G report critical incidents that do not involve restraint or seclusion. Examples of such incidents include potential crisis situations that are successfully de-escalated, accidental injuries that occur during recreation, and other significant events that require documentation.

Even sites that report critical incidents are not able to record all incidents in which restraint or seclusion is avoided; therefore, the actual number of critical incidents that do not involve restraint or seclusion may be far higher than reported here.

❖ **Demographics**

- Of those incidents that do not involve restraint or seclusion, 44% of youth are Caucasian, 24% are African-American, 15% are biracial, and 3% are Hispanic.
- Male clients are involved in 59% of all critical incidents that are unrelated to restraint or seclusion.
- Youth over age 13 are involved in 80% of critical incidents unrelated to restraint or seclusion.

❖ **Precipitants**

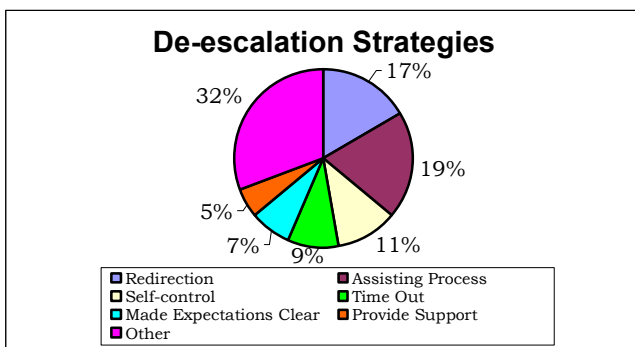
- Of those incidents that do not involve restraint or seclusion, 11% are precipitated by child on staff assault, 10% are precipitated by child on child assault, 10% are precipitated by youth being absent without leave (AWOL), and 7% are precipitated by property damage.

❖ **Injuries**

- Children are injured in 5% of incidents that do not involve physical intervention.
- Staff members are injured in .2% of incidents that do not involve restraint or seclusion.

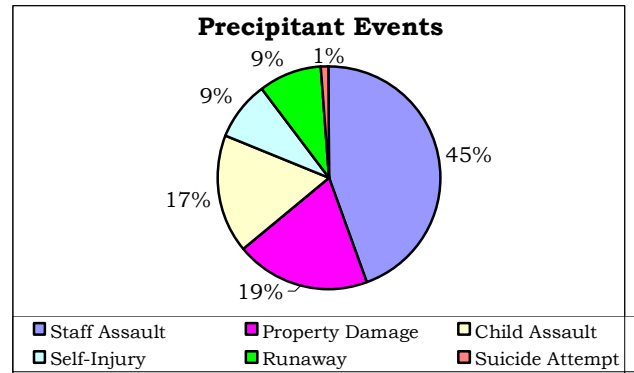
Behavior Support and Intervention

- ❖ **Pre-emptive Behavior Support:**¹² Of those sites that reported alternative intervention techniques, assisting process (19%), and redirection (17%) were the most frequently utilized de-escalation methods.

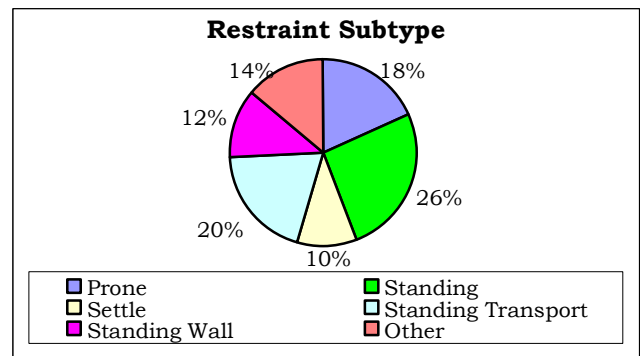


¹² Percentages may add up greater than 100% because more than one de-escalation technique may be used and recorded.

- ❖ **Precipitant Events**¹³: Child on staff assaults (45%), property damage (19%), and child on child assaults (17%) are the most frequently recorded precipitants of seclusion and restraint.



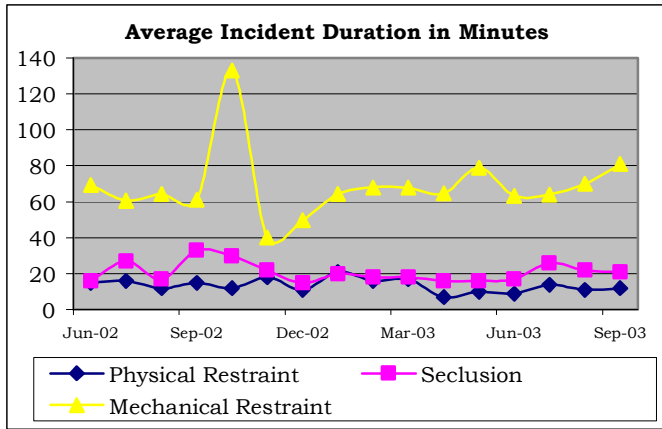
- ❖ **Physical Restraint Subtypes**¹⁴: Standing restraint (26%), standing transport (20%), and prone restraint (18%) were the most frequently used physical restraint techniques.



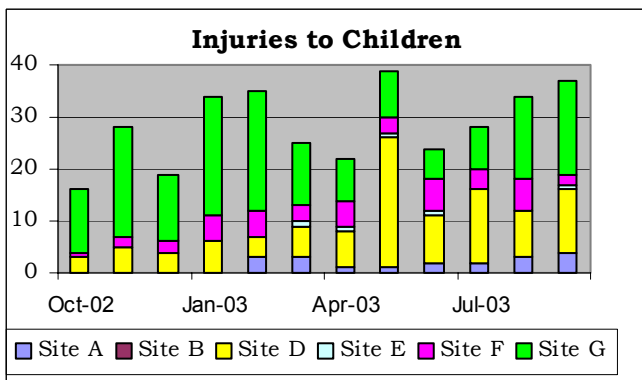
- ❖ **Duration:** Throughout the course of data collection, incidents of physical restraint lasted an average of approximately 14 minutes, seclusion incidents lasted approximately 21 minutes, and mechanical restraint incidents lasted approximately 69 minutes.

¹³ Not all sites provide precipitant event data. Percentages may add up greater than 100% because more than one de-escalation technique may be used and recorded.

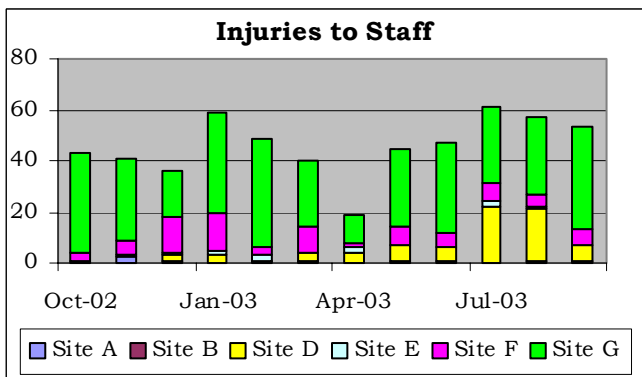
¹⁴ Not all sites provide restraint subtype data. Percentages may add up to greater than 100% because more than one restraint subtype can be used and recorded for any given incident.



❖ **Injuries¹⁵:** Overall, children were injured in 4% of the restraints and seclusions reported, and staff members were injured in 6% of all restraint and seclusions. There were two precipitous discharges, and no deaths reported as a result of restraint or seclusion.



Three percent of all seclusion incidents, 3% of all physical restraint incidents, and 8% of all mechanical restraint incidents resulted in injuries to children.



¹⁵ Injury data does not indicate whether injuries are occurring before or during emergency physical intervention.

Five percent of all physical restraint incidents, 6% of seclusions, and 16% of all mechanical restraint incidents resulted in injuries to staff members.

Other Findings of Note

- The majority of restraints and seclusions occur Monday through Thursday (65%).
- Monitoring during incidents was reported in 67% of cases reported.
- Debriefing children after incidents was reported in 43% of cases.
- Staff debriefing occurred after 32% of restraints and seclusions.

Tools

Learn more about these tools on the project website: www.cwla.org/programs/behavior

- ❖ **“Reducing the Use of Restraint and Seclusion: Successful Strategies and Promising Practices” Issue Brief:** The monograph details strategies facilities can implement to reduce restraint and seclusion.
- ❖ **Best Practices in Behavior Support and Intervention Training Guidelines (in press):** A National Task Force developed guidelines regarding information that should be included in behavior support and intervention training programs, as well as assigned risk factors to physical restraint techniques.
- ❖ **Behavior Support and Intervention Assessment Instrument (in press):** The self-assessment instrument is designed to assist programs in evaluating their behavior support and intervention policies and practices.
- ❖ **Effective Supervisory Practice: Behavior Support and Intervention for Children and Youth:** The curriculum for supervisors is currently being field-tested at project demonstration sites.

Project Dissemination Activities

- CWLA’s Tools That Work Conference, Miami, FL, November 12-14.
- Reducing the Use of Restraint and Seclusion: CWLA Teleconference Training, January 29, 2004.
- Children 2004: Vision, Action, Results, Washington, D.C., February 23-25, 2004.
- Evidenced Based Practice: Reducing Restraint, Plano, TX, April 22-23, 2004.
- CWLA’s Finding Better Ways, Atlanta, GA, May 3-5, 2004.

Coordinating Center Staff

Lloyd Bullard, Project Director
Darren Fulmore, Research Associate
Katie Johnson, Research Assistant
Nupur Gupta, Project Assistant
Dennis Braziel, Onsite Consultant to Connecticut Collaboration for Training Excellence
Laurie Cunningham, Onsite Consultant to Lakeside Treatment & Learning Center
Joe Healy, Onsite Consultant to University of Alabama's Brewer-Porch Children's Center
Andy Reitz, Onsite Consultant to A.B. and Jessie Polinsky Children's Center
Ginnie Waldron, Onsite Consultant to Methodist Home
Email: behaviormanagementtraining@cwla.org

Federation of Families for Children's Mental Health

Mary Telesford, Project Consultant

COME SEE US ONLINE AT

<http://www.cwla.org/programs/behavior/>

Website Includes:

- Project Updates
- Important Links
- Evaluation Findings
- Comprehensive Annotated Bibliography
- National and State regulations governing restraint and seclusion

Child Welfare League of America

HEADQUARTERS
440 First Street, NW Third Floor
Washington, DC 20001-2085
202/638-2952 – Fax 202/638-4004
www.cwla.org

The Child Welfare League of America (CWLA) is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

Credits

© 2003 CWLA. **The National Evaluation Quarterly Report Card** is published by the Child Welfare League of America. It is a product of the Coordinating Center and the demonstration site efforts. Darren Fulmore, Ph.D., and Katie Johnson, MSW, MPP, prepared this research brief

Project Sites

1. **Girls and Boys Town National Training Center** (Boys Town, NE; www.boystown.org) in partnership with the **A.B. and Jessie Polinsky Children's Center** (San Diego, CA; www.wic.org/orgs/polinsky).
2. **Methodist Home for Children and Youth** (Macon, GA; www.themethodisthome.org).
3. **Lakeside Treatment and Learning Center** (Kalamazoo, MI; www.lakesidetlc.org).
4. **Connecticut Collaboration for Training Excellence:**
 - ◆ **Klingberg Family Centers** (New Britain, CT; www.klingberg.com)
 - ◆ **Devereux Glenholme School** (Washington, CT; www.theglenholmeschool.org)
 - ◆ **Riverview Hospital** (Middletown, CT).
5. **University of Alabama's Brewer-Porch Children's Center** (Tuscaloosa, AL; www.as.ua.edu/bp).

that summarizes a report on the activities and data collected for the Best Practices in Behavior Support and Intervention: Preventing and Reducing the Use of Restraint and Seclusion Project.