Considerations for Committee Work Regarding Minnesota Rules 9525.2700 – 9525.2810 (known as Rule 40)

A Review of the States and Related Resources

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Introduction

In July 2009, three plaintiffs filed a federal lawsuit regarding the use of restraint and other behavior control and related strategies. On December 5, 2011 Judge Donovan Frank approved the Jensen settlement agreement. The settlement agreement included a provision that calls for the modernization of Minnesota Rules 9525.2700 – 9525.2810 which govern the use of use of aversive and deprivation procedures in licensed facilities serving individuals who have intellectual and developmental disabilities (IDD) and "related conditions" in Minnesota.

According to a summary of the Settlement Agreement prepared by **Shamus P. O'Meara,** Settlement Class Counsel, the "Settlement Agreement dramatically improves treatment for residents including immediately discontinuing the use of mechanical restraint, manual restraint, prone restraint, chemical restraint, seclusion, and the use of painful techniques that seek to punish. The settlement also ensures there is a true emergency before an approved restraint can be used".

Finally, the agreement requires the State to review and update important State Rules (Minnesota Rules 9525.2700 – 9525.2810) protecting people with developmental disabilities, so that current best practices, positive behavioral supports, and appropriate placement plans are developed.

The Governor's Council on Developmental Disabilities (The Council) has a seat on the advisory committee to update Minnesota Rules 9525.2700 – 9525.2810. The Council reviewed every state rule governing the use of aversive and related procedures. The Council decided to have a systematic parallel review completed by an external independent expert.

The Council then contracted with Michael Mayer, Senior Partner of Community Resource Alliance (CRA) to prepare an abbreviated report that could be used by the Rule 40 Committee in their efforts going forward to revise and update Minnesota Rules 9525.2700 – 9525.2810. Derrick Dufresne, Senior Partner of CRA provided assistance in this effort.

This document represents a summary of the current state statues and related rules, policies, and procedures related to behavioral supports and interventions, focusing on restraint, seclusion, aversive and related procedures.
The Council recognizes that the revision process for Minnesota Rules 9525.2700 – 9525.2810 will be an ongoing and as such there may be multiple versions of this document. Each will be dated accordingly.

The intent of this document is to highlight practices that could be particularly helpful to the committee that will be updating Minnesota Rules 9525.2700 – 9525.2810 rather than provide an encyclopedia review of all practices.

The abbreviated findings include:

1. Every state and the District of Columbia (herein after "states") currently have laws, rules, or policies that guide and restrict the use of restraints and all other aversive approaches. Punishment is largely prohibited in any form.

2. There is variation among the states regarding how they address the critical issues. It appears that this variation is related to the chronology of when those laws, rules, and policies were last revised. Those states that place more emphasis on positive behavioral supports have updated their rules more recently compared to Minnesota that promulgated its rule in 1987 with no update since that time.

3. Accreditation bodies, such as the Joint Commission, have recognized the extreme risks that restraint and isolation and proscribe such behavior severely.

4. According to the research, people who receive services in facilities that are subject to significant oversight by accreditors, monitors, government surveyors, or other authorities are likely to have fewer episodes of seclusion and restraint. In the absence of oversight, there is a higher risk that intrusive and dangerous interventions will be used inappropriately resulting in injury or death.

5. There is a broad legal foundation for freedom from restraint, isolation, and punishment in legal cases.

    - Virtually all legislatures have addressed seclusion and restraint issues, although not in a coordinated fashion, and in several cases as a direct result of legal challenge.

    - Federal regulations via the Centers for Medicare and Medicaid Services (CMS), which promulgated and enforces the regulations related to behavioral change and the use of seclusion and restraints in intermediate care facilities for people with IDD.

      A brief sampling of these regulations found in (42 CFR483.420, 440, and 450):

      Ensure that clients are not subjected to physical, verbal, sexual or psychological abuse or punishment … (42 CFR 483.420 (a)(5)).
      Note that restraints are addressed in a separate part.

      Designate these interventions on a hierarchy to be implemented, ranging from most positive or least intrusive, to least positive or most intrusive; (42 CFR 483.450 (b)(2)(ii))

      Insure, prior to the use of more restrictive techniques, that the client's record documents that programs incorporating the use of less intrusive or more positive techniques have been tried systematically and demonstrated to be ineffective… (42 CFR 483.450 (b)(1)(iii))

> Interventions to manage inappropriate behavior must be employed with sufficient safeguards and supervision to ensure that the safety, welfare and civil and human rights of (individuals) are adequately protected. (42 CFR 483.450 (b)(2))
>
> Techniques to manage inappropriate behavior must never be used for disciplinary purposes, for the convenience of staff or as a substitute for an active treatment program. (42 CFR 483.450 (b)(3))
>
> Standing or as needed programs to control inappropriate behavior are not permitted…(42 CFR 483.450 (b)(5))
>
> …emergency placement of a (person) into a time-out room is not allowed. (42 CFR 483.450 (c)(1)(i))

- Other Federal regulations strictly govern the use of seclusion and restraints in nursing homes that receive funds under Medicare or Medicaid (42CFR483.~~483~~.13[a]). This provision states "The resident has the right to be freee from any physical or chemical restraints imposed for purposes of discipline or convenience, and are not required to treat the resident's medical symptoms." These regulations ban all use of seclusion and all nonmedical use of restraints in covered nursing homes.

- The paramount legal case, *Wyatt v. Stickney (344 F.Supp.387 D.C.Ala* (1972)), affirms that residents have the right to be free from restraint and isolation, in addition to establishing several other functional rights of individuals with intellectual and developmental disabilities. (The ruling was issued in 1971. The 1972 Court Order identified 35 standards for adequate treatment).

The court ruled that those interventions may be used only when the resident might otherwise cause harm to himself or others and there is no less restrictive way to prevent such harm.

The above, in addition to the conditions of the Settlement Agreement, require that the review and revision process for Minnesota Rules 9525.2700 – 9525.2810 must be approached with a view to comprehensively revise the Rules to assure not only full and complete compliance with relative statutes and court rulings but also that the state establishes best practice for the benefit of the individuals served.

Review of Other State Rules and Recommendations

This report is prepared subsequent to an extensive review of the rules and policies and procedures related to behavioral management and support for all 50 states and the District of Columbia.

Abbreviated Summary of Findings

- Across almost all states there is a general stated intention to limit seclusion, restraint and aversive procedures and to manage PRN medications for behavioral control.

- Some regulations and guidelines are highly prescriptive (often in states with current or recent U.S. Department of Justice engagement) – others leave wide latitude for "professional judgment".

- States generally agree that unplanned procedures that involve restraint should be for emergencies only and never for punishment or as a consequence for behavioral problems.

- There is general agreement that staff should be trained in the techniques that they will be required to implement with some states specifying very detailed expectations of competencies to be demonstrated.

- Included below are a few of the elements that represent, or most closely approach, best practice from the perspective of the Positive Behavior Supports (PBS) community. In general, the states with the most precise definitions are also the states with the lowest tolerance for restraint and which make it very complex for invasive, intrusive, aversive, or restraints to occur.

Arizona describes "abusive treatment" as "inflicting pain or injury" to a person, and includes emotional and programmatic abuse. Programmatic abuse includes the use of an aversive stimuli that has not been approved as a part of such person's individual program plan and which is not contained in the rules and regulations adopted pursuant to subsection B of section 36-561(per their requirements), which includes isolation or restraint *(6-569 Prohibitions; violations; classification)*.

Within their definition of neglect, they include:

(d) Intentional failure to carry out a prescribed treatment plan… (AZ 36-569)

Arkansas policy, like virtually all states, is to "utilize all positive approaches to behavior management prior to and in conjunction with more restrictive programmatic techniques. **Positive approaches may include, but are not limited to: positive reinforcement, gentle teaching, redirection, graduated guidance, and modeling of appropriate behaviors.** Measures to address positive behavior should be incorporated into formal program efforts to the extent feasible. *(emphasis added)*

Later on as emergency procedures are discussed in a policy manual regarding the Arkansas rule it states:
"However, it is emphasized that emergency procedures are not to be used at frequent intervals, becoming a routine method of intervention. *(emphasis per original).*

They further "expressly prohibit" corporal punishment. Corporal punishment is defined as *"the application of painful stimuli as a penalty for certain behavior, and includes…the use of electrical shock or other infliction of pain, whether or not applied as a part of systematic behavior intervention program."*

California makes a strong statement regarding behavioral "interventions that restrict personal freedom and liberty constitute an infringement on individual rights and an intrusion into a person's life. These procedures may also be stigmatizing to the recipient…they require appropriate safeguards, including ongoing approval, monitoring, and oversight mechanisms" (California Developmental Centers Division Policy Memorandum).

"Restraint use even in emergency situations is very dangerous to the individual being restrained"

Additional comments regarding the findings within specific states follow the recommendations section.

Abbreviated Recommendations

1. Engage in a careful review of the Arizona DES, Division of Developmental Disabilities, Policies and Procedures Manual, Policy 1600, Managing Inappropriate Behavior for application in Minnesota.
2. Consider incorporating significant elements of the document "Guidelines for Supporting Adults with Challenging Behaviors in Community Settings" from the Georgia. It serves as a strong document to support the current efforts.

   Note: Virtually of the general comments that are included herein, that are not identified as being state specific, are incorporated in the documents mentioned above.

3. Apply all related rules to all settings that are designated for the support of people who have IDD (many states).

4. Require any behavior plan to have active positive behavioral and social supports support to teach alternative and replacement behaviors. Mandate the use of all relevant Positive Behavior Support approaches. (Wisconsin)

5. Create technical assistance and training network to assure that staff are competent in required content and verify that all potential positive approaches have been correctly attempted with the variations necessary to address the person specific needs.

6. Establish minimum initial and ongoing training requirements, to include competency demonstrations of at least the items specified in this list of recommendations and:
    a. primary preventative measures rather than restraint;
    b. interventions that are less intrusive than restraints;
    c. effective ways to de-escalate situations to avoid restraints; and
    d. crisis intervention techniques that utilize alternatives to restraint.

7. Assure that all people who will be expected to implement a behavior support plan will have received training and demonstrated competency in that plan prior to being permitted to implement the plan.

8. Create a robust approval and review mechanism with enhanced government oversight of restraint usage, injuries, deaths and other serious problems related to restraints with sufficient resources to ensure the effectiveness of the oversight. Agency driven processes are insufficient.

9. Conduct ongoing monitoring and oversight of each restraint incident by key agency leadership staff and representatives of the state that includes a prompt and thorough review of the incident as a means to ensure safety.

10. Ensure ongoing collection and analysis of restraint incident data as a method to prevent other incidents of restraint.

11. Establishing strict enforcement methods that will ensure compliance with planning and reporting requirements related to all behavior intervention plans that involve anything other than distinctly positive efforts, especially restraints, including the use of meaningful sanctions for failure to comply.

12. Agencies must establish policy and procedures that strictly enforce the limited circumstances under which the law currently allows restraints to be applied, and must provide ongoing staff training to ensure that, if used, restraints are done in a manner least likely to cause injury or death.

13. Prohibit dangerous practices, including the use of restraint when it is contraindicated by the person's medical or psychological condition.

14. After the first emergency, and/or before the implementation of a behavior plan, rule out the potential effects of existing medical conditions on behavior. Per Wyatt v. Stickney, no individual "shall be subjected to a behavior modification program designed to eliminate a particular pattern of behavior without prior certification by a physician that he has examined the resident in regard to behavior to be extinguished and finds that such behavior is not caused by a physical condition which could be corrected by appropriate medical procedures." (Alabama)

15. After the first emergency, determine if there are any medical conditions which make an emergency restraint contraindicated, and if so, develop person specific responses. This shall at the least require and analysis of cardiac and respiratory function and a bone density test to determine if the individual can withstand typical emergency restraint techniques. (Connecticut) Other medical conditions to consider include:
    a. Morbid obesity should be a contraindication to restraint because of the increased risk of death due to asphyxia (obesity may be considered a contraindication for the same reason);
    b. Intoxication, either due to drugs or alcohol, may be a contraindication because of the increased risk of death due to spontaneous apnea;
    c. Development of a deep vein thrombosis (blood clot) is a serious risk of being restrained, especially for people who are restrained for prolonged periods.

16. Require that plans may not be changed outside of the formal person centered behavior support planning process and that every behavior support plan shall be included as a part of the person-centered program plan. (Washington)

17. Require that any practice/behavior support technique be supportable by contemporary evidence of efficacy in peer reviewed publications, in addition to compliance with rule and law (Michigan)

18. Any time an emergency procedure is used two or more times in six month period the team must meet to review the plan, including the behavior support plan (Alabama)

19. Carefully describe brief manual holds. Georgia specifies that it is 10 seconds or less.

20. Required debriefing, with specified elements after an emergency with the intention of using that information, via interaction guidelines, plan alternations, alternative supports, etc. to reduce the likelihood of future emergencies (Georgia, Kentucky)

21. Specifically prohibit behavior plans and behavior change efforts which attempt to extinguish typical adult/socially appropriate behavior or to develop new behavior patterns when such behavior modifications serve only organizational or program convenience. (also per Wyatt v. Stickney)

22. Establish minimum supervision and monitoring of staff who may be required to provide emergency behavioral supports. (National Review)

23. Require training for all staff that enables them to competently identify signs of distress that require cessation of emergency restraint and/or medical intervention. Establish

that inadequate response by the staff to the person's distress in an emergency and/or restraint constitutes neglect. (National Review)

24. Establish minimum use of force expectations and distinct training of specific non-restraint techniques that can be used in emergencies to prevent injury to self or others mandate third party verification of staff competency to demonstrate these skills.

25. Mandate specific efforts and reporting requirements to assure that all reasonable less intrusive interventions have been attempted before restraining the person in an emergency and mandate third party verification of staff competency to demonstrate these skills.

26. Prior to implementation of a behavior change plan, require the provision of adequate alternative treatment options, including environmental enhancements and alternatives to traditional treatment methods, such as the use of comfort rooms, sensory integration tools, and creative calming approaches.

27. Practices recommended to Prohibit:
    a. Overcorrection
    b. Psychological, mental, or emotional harm caused by…intimidation, humiliation, harassment, threats of punishment, or deprivation (Indiana).
    c. The implementation of a behavior plan by someone not specifically trained and having demonstrated competency (North Carolina)
    d. Modification of any behavior plan or the implementation of any plan outside of the formal behavior plan development process (North Carolina)
    e. Use of any reactive strategy on a "PRN" or "as required" basis (District of Columbia)

28. Practices recommended to severely limit via extensive review
    a. Any plan that includes a technique involving force or forced compliance;
    b. Any plan that includes a delay of basic human need or which may otherwise infringe on the rights of the individual according to state and federal rules and laws, including but not limited to food
    c. Any plan involving response cost;
    d. Protective devices used to prevent an individual from sustaining injury as a result of the individual's self-injurious behavior;
    e. Any restriction of visitors and/or phone privileges requires "sufficient documentation/data showing the connection between the visits/calls and the target behavior occurrence" and further, there must be a procedure to "regain access to visitors/phone calls" (Alabama).

29. Proposed plans involving any restricted practice shall be investigated to assure:

a. The practice/behavior support technique be supportable by evidence of efficacy in peer reviewed publications, in addition to compliance with rule and law
b. That potential alternative methods which do not involve these techniques have been appropriately attempted and were not successful.
c. That there is agreement that the interventions approved are the least intrusive approach and present the least restrictive alternative.
d. Any such plan must be reviewed not less than monthly for continuation.
e. Within three working days of an emergency incident, the interdisciplinary team, including the physician, shall review the client and his or her environment to determine if changes in the plan including continued use of the emergency procedures are required. (Alabama)
f. The restrictive review committee shall include a majority of persons who do not provide services to the individual (Pennsylvania)

Additional Notations from Across the States

Arkansas: Anomaly in some ways, like the ability to assign additional chores. Detailed process but it is not strong. Weak information provided on safeguards.

Delaware: Clearly integrates the Person Centered Plan with the concepts of PBS. Strong and detailed processes and expectations. Generally very "consumer friendly". Risk/benefit reviews and other information not usually found in other states. Recommend careful review of their rules.

Kansas: Safeguards; Excellent information in their training manual on PBS.

Kentucky: A strong model with structured accountability. Worth reviewing carefully.

Michigan: Scientific standards must be met to allow any non-positive behavior approach (peer-reviewed literature, etc.). Focus on improving the quality of life of the individual. No mechanical devices except in hospital or state-operated facility. Strong committee standards and directives. TA and training functions outlined. Clear requirements for behavior plans (standards). Recommend careful review.

Oklahoma: Language and related behavior is spelled out (swearing, name calling, etc.). Protective intervention plan and risk assessment, including program and service requirements and detailed instructions and procedures required. Expecting dignity and respect…"not controlling". Field Specialists (TA). Physical management must be terminated as soon as the person is calm or the threat has ended and *must never exceed two minutes at a time. (emphasis added).* Strong trainer requirements. Recommend careful consideration.

Montana: Listing of non-aversives/alternatives to punishments they expect to see attempted. Not much else worth noting.

Vermont: Excellent Behavior Support Guidelines document with clear requirements and accountability forms for different types of behavior support plans. Very clear prohibitions (non-negotiable). Content worth considering for training.
Washington: Clear list of non-restrictive physical interventions. Clear requirements for Physical Intervention Techniques System. Very detailed information on what is permitted and prohibited. *Strong process for approvals/committee work*. Several items that are in direct conflict with MN policy on prohibitions, etc. See Chapter 5, pages 3-8, 10-12 of 22 in DDD Policy Manual. Strong on rights. Requirements for treatment of sexual deviancy. Some good information that could be incorporated into MN.

What is the Definition of Emergency?

There is a general consensus around basic definitions. We have added emphasis to some of the unique elements of the definitions from select states.

Arizona: Imminent and immediate need for safety intervention to prevent dire consequences – episodic and not planned.

> *Physical management techniques employed in an emergency to manage a sudden, intense, or out-of-control behavior shall:*
>
> 1. *Use the least amount of intervention necessary to safely physically manage an individual.*
> 2. *Be used only when less restrictive methods were unsuccessful or are inappropriate.*
> 3. *Be used only when necessary to prevent the individual from harming self or others or causing severe damage to property.*
> 4. *Be used concurrently with the uncontrolled behavior*
> 5. *Be continued for the least amount of time necessary to bring the individual's behavior under control.*
> 6. *Be appropriate to the situation to ensure safety.*

Emergency measures, including PRN behavior modifying medications require immediate reporting to DD authorities and 24 hrs. to complete a detailed written report.

If an emergency measure is utilized two or more times in a 30-day period the case manager must reconvene the team to determine the need for a new or revised plan. The same is true if there is "any identifiable pattern."

Colorado: Serious, probably, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.

Delaware: Unanticipated and already occurring event such as severe aggressive behavior that is placing the individual or others in imminent danger of physical harm

Illinois: The individual's behavior presents an immediate and imminent risk of physical harm to self or others.

Louisiana: A crisis pertaining to imminent danger and grave risk of injury to self or others.

Maine: A situation in which an individual's behavior appears to present imminent danger to the individual or others. Risk of criminal detention or arrest may constitute an emergency.

Maryland: A situation in which an individual's behavior appears to present imminent danger to the individual or to others.

Massachusetts: …such as the occurrence of, or serious threat of, extreme violence, personal injury, or attempted suicide.

Missouri: There is imminent danger or potential harm to a client or other persons.

Montana: …those situations for which no approved individual program plan exists and which, if not dealt with, may result in injury to the client or other persons or significant amounts of property destruction.
Nebraska: There is an imminent risk of an individual physically harming him/herself, staff, or others and non-physical interventions have not been effective.

Nevada: Emergency is defined as a serious, probable, or imminent threat of bodily harm to self or others where there is the real potential to cause bodily harm.

Oklahoma: Emergency intervention is the use of a restrictive or intrusive procedure(s) not included in a protective intervention plan in response to an unanticipated and unpredictable situation or event or the sudden occurrence of an event so severe and dangerous that urgent action precludes less restrictive measures.

Tennessee: If an individual falls to the ground/floor…he or she is no longer a danger to others. If an individual is likely to, or attempts to, injure him or herself while on the floor, he or she may be restrained for safety.

Utah: Emergency situation means one or more of the following:

(1) Danger to others: physical violence toward others with sufficient force to cause bodily harm
(2) Danger to self: abuse of self with sufficient force to cause bodily harm
(3) Danger to property: physical abuse or destruction of property
(4) Threatened abuse toward others, self, or property which, with an evidence of past threats, results in any of the items listed above.

Recommendations and Comments Regarding Minnesota Rules, Parts 9525.2700 through 9525.2810

Rule 40. Use of Aversive and Deprivation Procedures in Licensed Facilities Serving Persons with Developmental Disabilities.

Select areas of consideration for changes are highlighted. Comments by the author/consultant regarding the highlight are underlined in smaller font.

1. The author suggests that the Rule be reframed as "Prohibited, Controlled, and Emergency Practices" or something similar. These should be the extremely rare exception to the rule. This will affect several sections of language.
2. The out of date language of "Mental Retardation" should be replaced with "Intellectual and Developmental Disabilities" throughout this document.
3. There are many procedures that are positive that should be considered for inclusion as "expected" or "best practice" prior to using any controlled procedure. Positive Behavior Supports should be a specific requirement.
4. There are quite a few outdated principles and practices (as well as language) that should be revised in this rule. Notes were made in several locations, but it remains a general concern as well.
5. Careful explanation of the prohibited items per the Settlement Agreement must include mechanical restraint, manual restraint, prone restraint, chemical restraint, seclusion, and the use of punishment of residents with intellectual and developmental disabilities. Practices which have the same effect of the above practices should be clearly prohibited (such as papoose wraps)

9525.2700 PURPOSE AND APPLICABILITY.

Subpart 1. **Purpose**. Parts 9525.2700 to 9525.2810 implement Minnesota Statutes, section 245.825 by setting standards that govern the use of aversive and deprivation procedures with persons who have mental retardation or a related condition and who are served by a license holder licensed by the commissioner under Minnesota Statutes, chapter 245A and section 252.28, subdivision 2.

Parts 9525.2700 to 9525.2810 are not intended to encourage or require the use of aversive and deprivation procedures. Rather, parts 9525.2700 to 9525.2810 encourage the use of positive approaches as an alternative to aversive or deprivation procedures and require documentation that positive approaches have been tried and have been unsuccessful as a condition of implementing an aversive or deprivation procedure.

(Reframe: intended to severely restrict or prohibit the use of aversive and deprivation procedures…)

The standards and requirements set by parts 9525.2700 to 9525.2810:

A. exempt from the requirements of parts 9525.2700 to 9525.2810 any procedures that are positive in approach or are minimally intrusive;

B. prohibit the use of certain actions and procedures specified in part 9525.2730;

C. control the use of aversive and deprivation procedures permitted under parts 9525.2700 to 9525.2810 by requiring development of an individual service plan, development of an individual program plan, informed consent from the person or the person's legal representative, and review and approval by the expanded interdisciplinary team and internal review committee;

D. establish criteria and procedures for emergency use of controlled aversive and deprivation procedures; and

E. assign a monitoring and technical assistance role to the regional review committees mandated by Minnesota Statutes, section 245.825.

Subp. 2. **Applicability**. Parts 9525.2700 to 9525.2810 govern the use of aversive and deprivation procedures with persons who have mental retardation or a related condition when those persons are served by a license holder:

A. licensed under parts 9525.1500 to 9525.1690 to provide training and habilitation services to adults with mental retardation or a related condition;

B. licensed under parts 9525.0215 to 9525.0355 as a residential program for persons with mental retardation or a related condition. If a requirement of parts 9525.0215 to 9525.0355 differs from a requirement in Code of Federal Regulations, title 42, sections 483.400 to 483.480, an intermediate care facility for persons with mental retardation or a related condition shall comply with the rule or regulation that sets the more stringent standard;

C. licensed under parts 9525.2000 to 9525.2140 to provide residential-based habilitation services;

D. licensed under parts 9503.0005 to 9503.0175 and 9545.0750 to 9545.0855 to provide services to children with mental retardation or a related condition;

E. licensed under parts 9555.9600 to 9555.9730 as an adult day care center;

F. licensed under parts 9555.5105 to 9555.6265 to provide foster care for adults or under part 9545.0010 to 9545.0260 to provide foster care for children; or

G. licensed for any other service or program requiring licensure by the commissioner as a residential or nonresidential program serving persons with mental retardation or a related condition, as specified in Minnesota Statutes, section 245A.02.

Subp. 3. **Exclusion**. Parts 9525.2700 to 9525.2810 do not apply to:

A. treatments defined in parts 9515.0200 to 9515.0800 governing the administration of specified therapies to committed patients residing at regional centers; or

The author suggests defining those in detail here. Further, the author suggests that the limitations should apply across the board, without exemption or exclusion. Where someone resides should not determine the degree of humanity that we demonstrate toward them. Calling something a treatment does not make it therapeutic, just as calling something therapeutic does not make it helpful. Also, recommend changing "patients" to residents throughout.

B. residential care or program services licensed under parts 9520.0500 to 9520.0690 to serve persons with mental illness.

Subp. 9. **Controlled procedure**. "Controlled procedure" means an aversive or deprivation procedure that is permitted by parts 9525.2700 to 9525.2810 and is implemented under the standards established by those parts. Controlled procedures are listed in part 9525.2740.

Subp. 12. **Deprivation procedure**. "Deprivation procedure" means the removal of a positive reinforcer following a response resulting in, or intended to result in, a decrease in the frequency, duration, or intensity of that response. Often times the positive reinforcer available is goods, services, or activities to which the person is normally entitled. The removal is often in the form of a delay or postponement of the positive reinforcer.

(Please see later comments. Largely considered an out of date practice.)

Subp. 13. **Emergency use**. "Emergency use" means using a controlled procedure without first meeting the requirements in parts 9525.2750, 9525.2760, and 9525.2780 when it can be documented under part 9525.2770 that immediate intervention is necessary to protect a person or other individuals from significant and immediate physical injury or to prevent severe property damage which is an immediate threat to the physical safety of the person or others.

Subp. 14a. **Expanded interdisciplinary team**. "Expanded interdisciplinary team" means a team composed of the case manager; the person with mental retardation or a related condition; the person's legal representative and advocate, if any; representatives of providers of residential, day training and habilitation, and support services identified in the person's individual service plan; a health professional, if the person with mental retardation or a related condition has overriding medical needs; and a qualified mental retardation professional. The qualified mental retardation professional must have at least one year of direct experience in assessing, planning, implementing, and monitoring a plan that includes a behavior intervention program.

Subp. 19a. **Internal review committee**. "Internal review committee" means the committee responsible under part 9525.2750, subpart 2, for the review and approval of individual program plans proposing the use of controlled procedures.

Subp. 22. **Manual restraint**. "Manual restraint" means physical intervention intended to hold a person immobile or limit a person's movement by using body contact as the only source of physical restraint. The term does not mean physical contact used to: (1) facilitate a person's completion of a task or response when the person does not resist or the person's resistance is minimal in intensity and duration; (2) escort or carry a person to safety when the person is in danger; or (3) conduct necessary medical examinations or treatments.

(Please see later comments.)

Subp. 23. **Mechanical restraint**. "Mechanical restraint" means the use of devices such as mittens, straps, restraint chairs, or papoose boards to limit a person's movement or hold a person immobile as an intervention precipitated by a person's behavior. The term does not apply to mechanical restraint used to treat a person's medical needs, to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's individual program plan. The term does apply to, and parts 9525.2700 to 9525.2810 do govern, mechanical restraint when it is used to prevent injury with persons who engage in behaviors, such as head-banging, gouging, or other actions resulting in tissue damage, that have caused or could cause medical problems resulting from the self-injury.

The author's concern here is that the exemption of the protective devices from the mechanical restraint category may imply that it is appropriate to continue to use these without any effort to train positive replacement/alternative behaviors. Please see comments later. Mechanical restraint is one of the most severely restricted options in virtually every state.

(Mechanical restraints must explicitly include reference to items such as metal handcuffs, leg hobbles, cable tie cuffs, plasticuffs, flexicuffs, soft cuffs, posey cuffs or items which have the same effect as these items. There should be no mistake about what is specifically prohibited.)

Subp. 25. **Positive practice overcorrection**. "Positive practice overcorrection" means a procedure that requires a person to demonstrate or practice a behavior at a rate or for a length of time that exceeds the typical frequency or duration of that behavior. The behaviors identified for positive practice are typically appropriate adaptive behaviors or are incompatible with a behavior identified for reduction or elimination in a person's individual program plan.

(At the point that anything becomes annoying, or resisted, it is by definition, aversive. Positive practice should not be forced or required – with implied punishment for failure to comply. It is very easy for positive practice to become problematic and exacerbate underlying problems, etc.)

Subp. 26. **Positive reinforcement**. "Positive reinforcement" means the presentation of an object, event, or situation following a behavior that increases the probability of the behavior

recurring. Typically, the object, event, or situation presented is enjoyable, rewarding, or satisfying.

Subp. 29. **Regional review committee.** "Regional review committee" means a committee established by part 9525.2790 to monitor parts 9525.2700 to 9525.2810 as mandated by Minnesota Statutes, section 245.825. Review committee jurisdictions and responsibilities are defined in part 9525.2790.

Subp. 31. **Restitutional overcorrection**. "Restitutional overcorrection" means a procedure that requires a person to clean, repair, or correct an area or situation damaged or disrupted as a result of the person's behavior to a point where the area or situation is not only restored to but exceeds its original condition.

(This is a form of punishment and should be labeled and treated as such. Out of date practice.)

Subp. 32. **Seclusion**. "Seclusion" means the placement of a person alone in a room from which egress is:

A. noncontingent on the person's behavior; or

B. prohibited by a mechanism such as a lock or by a device or object positioned to hold the door closed or otherwise prevent the person from leaving the room.

Subp. 33a. **Substantial change**. "Substantial change" means a change in the individual program plan that intensifies the intrusiveness of the controlled procedure by:

A. expanding, adding, or replacing in any way:

(1) the target behaviors for which the controlled procedure is to be implemented; or

(2) the type of controlled procedure;

B. the method of implementation;

C. the criteria for change or the criteria for termination of implementation of the controlled procedure; or

D. deleting without replacing a target behavior. (<u>This should be re-written for clarity</u>)

Subp. 35. **Time out or time out from positive reinforcement**. "Time out" or "time out from positive reinforcement" means removing a person from the opportunity to gain positive reinforcement and is employed when a person demonstrates a behavior identified in the individual program plan for reduction or elimination. Return of the person to normal activities from the time out situation is contingent upon the person's demonstrating more appropriate behavior. Time out periods are usually brief, lasting only several minutes. Time out procedures governed by parts 9525.2700 to 9525.2810 are:

A. "exclusionary time out," which means removing a person from an ongoing activity to a location where the person cannot observe the ongoing activity; and

B. "room time out," which means removing a person from an ongoing activity to an unlocked room. The person may be prevented from leaving a time out room by staff members but not by mechanical restraint or by the use of devices or objects positioned to hold the door closed.

(Forced engagement in time out, where the individual physically resists, can quickly become a physical altercation, which some would use as justification for "emergency restraint/procedures." All time out rooms should be unlocked. It is also easy for time out to transform into seclusion if not carefully monitored)

9525.2720 EXEMPTED ACTIONS AND PROCEDURES.

Use of the instructional techniques and intervention procedures listed in items A to H is not subject to the restrictions established by parts 9525.2700 to 9525.2810. The person's individual program plan must address the use of the following exempted actions and procedures:

A. Corrective feedback or prompts to assist a person in performing a task or exhibiting a response.

B. Physical contact to facilitate a person's completion of a task or response and directed at increasing adaptive behavior when the person does not resist or the person's resistance is minimal in intensity and duration, as determined by the expanded interdisciplinary team.

(Minimal has different meanings to people. Perhaps this should be explained more concretely to prevent confusion. See C(3) below as an example.)

C. Physical contact or a physical prompt to redirect a person's behavior when:

(1) the behavior does not pose a serious threat to the person or others; (Whose behavior and why must it be a "serious" threat? Are we referencing and/or trying to govern the behavior of the person with IDD or the staff?)

(2) the physical contact is used to escort or carry a person to safety when the person is in danger; (Which should qualify this as an "emergency" procedure and be covered under those requirements)

(3) the behavior is effectively redirected with less than 60 seconds of physical contact by staff; or (What about a series of "60 second" physical contacts? The author suggests that this should be limited by frequency and intensity, not simply duration.

(4) the physical contact is used to conduct a necessary medical examination or treatment.

This exemption may not be used to circumvent the requirements for controlling the use of manual restraint. It is included to allow caregivers the opportunity to deal effectively and naturally with intermittent and infrequently occurring situations by using physical contact.

D. Positive reinforcement procedures alone or in combination with the procedures described in items A and B to develop new behaviors or increase the frequency of existing behaviors.

(Perhaps this is the best place to identify a list of potential positive practices that should be used – practices that are endorsed and encouraged. Regardless of where they are located, it should be a requirement that these approaches such as Differential Reinforcement of Other Behavior (DRO),

Differential Reinforcement of High Rates of Behavior (DRH), etc. be used prior to any approval for restrictive/intrusive intervention plans.)

E. Temporary interruptions in instruction or ongoing activity in which a person is removed from an activity to a location where the person can observe the ongoing activity and see others receiving positive reinforcement for appropriate behavior. Return of the person to normal activities is contingent upon the person's demonstrating more appropriate behavior. This procedure is often referred to as contingent observation.

F. Temporary withdrawal or withholding of goods, services, or activities to which a person would otherwise have access as a natural consequence of the person's inappropriate use of the goods, services, or activities. Examples of situations in which the exemption would apply are briefly delaying the return of a person's beverage at mealtime after the person has thrown the beverage across the kitchen or temporarily removing an object the person is using to hit another individual. Temporary withdrawal or withholding is meant to be a brief period lasting no more than several minutes until the person's behavior is redirected and normal activities can be resumed.

(Whenever we need to contrive an intervention it is not "natural" in and of itself. Natural consequences occur without any staff or professional intervention. Any time you withdraw something that the individual normally would have access to it is a form of punishment or it is protective, such as taking away the fork so the individual does not stab themselves with it again. This is not to say that there is no place for this technique, just that it be labeled appropriately and controlled as any mild punishment approach would be. "Brief" and "temporary" are, again, easily interpreted to mean different things, thus, the definition here is a valuable start.)

G. Token fines or response cost procedures such as removing objects or other rewards received by a person as part of a positive reinforcement program. Token fines or response cost procedures are typically implemented after the occurrence of a behavior identified in the individual program plan for reduction or elimination. Removing the object or other reward must not interfere with a person's access to the goods, services, and activities protected by part 9525.2730.

The author has yet to see this end well/constructively. Taking away something already earned has its problems – not the least of which is the absence of due process. It is a form of punishment and thus, aversive in nature. Several states have specifically limited or prohibited this approach. Token systems are generally considered an out of date technology with significant limitations and potentially serious ramifications.

H. Manual or mechanical restraint to treat a person's medical needs, to protect a person known to be at risk of injury resulting from lack of coordination or frequent loss of consciousness, or to position a person with physical disabilities in a manner specified in the person's individual program plan.

(This should be part of an comprehensive treatment strategy and not applied outside of the treatment setting by a qualified practitioner of the healing arts without a prescription for these. This can include OT, PT, nursing, etc. It should be well documented that other attempts to address these concerns have not been successful prior to reliance upon them as a permanent protective appliance or procedure.)

9525.2730 PROCEDURES AND ACTIONS RESTRICTED OR PROHIBITED.

(This section should be carefully detailed.)

Subpart 1. **Restrictions**. An aversive or deprivation procedure must not:

A. be implemented with a child in a manner that constitutes sexual abuse, neglect, or physical abuse as defined in Minnesota Statutes, section 626.556, which governs the reporting of maltreatment of minors;

B. be implemented with an adult in a manner that constitutes abuse or neglect as defined in Minnesota Statutes, section 626.557, which governs the reporting of maltreatment of vulnerable adults;

C. restrict a person's normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing as mandated by Minnesota Statutes, section 245.825, or to any protection required by state licensing standards and federal regulations governing the program; or

D. deny the person ordinary access to legal counsel and next of kin as mandated by Minnesota Statutes, section 245.825.

Subp. 2. **Prohibitions**. The actions or procedures listed in items A to I are prohibited:

A. using corporal punishment such as hitting, pinching, or slapping;

B. speaking to a person in a manner that ridicules, demeans, threatens, or is abusive;

C. requiring a person to assume and maintain a specified physical position or posture as an aversive procedure, for example, requiring a person to stand with the hands over the person's head for long periods of time or to remain in a fixed position;

D. placing a person in seclusion;

E. totally or partially restricting a person's senses, except as expressly permitted in part 9525.2740, subpart 1;

F. presenting intense sounds, lights, or other sensory stimuli as an aversive stimulus;

G. using a noxious smell, taste, substance, or spray, including water mist, as an aversive stimulus;

H. using room time out in emergency situations; and

I. denying or restricting a person's access to equipment and devices such as walkers, wheelchairs, hearing aids, and communication boards that facilitate the person's functioning. When the temporary removal of the equipment or device is necessary to prevent injury to the person or others or serious damage to the equipment or device, the equipment or device must be returned to the person as soon as possible.

(There should be an explicit statement that there will be no exceptions to the above prohibitions, regardless of the setting or rationale.)

Subp. 3. **Faradic shock**. Emergency use of faradic shock as an aversive stimulus is prohibited. Use of faradic shock as an aversive stimulus is permitted only when all of the following conditions are met:

A. the target behavior is extreme self-injury that threatens irreparable bodily harm;

B. it can be documented that other methods of treatment have been tried and were unsuccessful in controlling the behavior;

C. a state or federal court orders the use of faradic shock;

D. use of faradic shock ordered by a court is implemented in accordance with parts 9525.2750 and 9525.2760; and

E. a plan is in effect to reduce and eliminate the use of faradic shock with the person receiving it.

(This is an out of date practice that is prohibited in virtually every setting and is classified as abusive. There should be an explicit statement that there are no exceptions permitted.)

9525.2740 PROCEDURES PERMITTED AND CONTROLLED.

Subpart 1. **Controlled procedures**. The procedures listed in items A to G are permitted when the procedures are implemented in compliance with parts 9525.2700 to 9525.2810. Permitted but controlled procedures, referred to as controlled procedures, are:

A. exclusionary and room time out procedures; (See earlier comments.)

B. positive practice overcorrection; (See earlier comments. This must be very carefully constrained if used)

C. restitutional overcorrection; (See earlier comments. The author remains un-persuaded that this is a good approach. Further, it is likely to cause reactionary behavior that could justify a restraint. This practice should be prohibited.)

D. partially restricting a person's senses at a level of intrusiveness that does not exceed placing a hand in front of a person's eyes as a visual screen or playing music through earphones worn by the person at a level of sound that is pleasant/enjoyable does not cause discomfort; (see insert highlighted)

E. manual restraint; (This should be severely limited to be permissible in emergencies only)

F. mechanical restraint; (This should be even more severely limited than manual – if not prohibited outright - only permissible in extreme emergency situations and never as a part of a planned program of intervention/treatment/training) and

G. deprivation as defined in part 9525.2710, subpart 12. (This approach is a form of punishment, therefore aversive, and can quickly escalate behavior. It must be severely limited if not eliminated.)

Subp. 2. **Authorization for procedures not specified as exempted, restricted, prohibited, or controlled**. If an expanded interdisciplinary team prepares a plan proposing the use of an aversive or deprivation procedure that is not specifically exempted by part 9525.2720, or specifically prohibited or restricted by part 9525.2730, or specifically permitted and controlled

by subpart 1, the case manager shall request authorization for the use of that procedure from the regional review committee. If a procedure is authorized by a regional review committee, use of the procedure is subject to the controls established in parts 9525.2700 to 9525.2810.

9525.2750 STANDARDS FOR CONTROLLED PROCEDURES.

Subpart 1. **Standards and conditions**. Except in an emergency governed by part 9525.2770, use of a controlled procedure may occur only when the controlled procedure is based upon need identified in the individual service plan and is proposed, approved, and implemented as part of an individual program plan. Use of a controlled procedure within an individual program plan must comply with items A to I.

A. The controlled procedure is proposed or implemented only as a part of the total methodology specified in the person's individual program plan. The individual program plan has as its primary focus the development of adaptive behaviors and communication skills. The controlled procedure proposed ~~approved~~ must represent~~s~~ the lowest level of intrusiveness ~~required~~ possible to influence the target behavior and is not excessively intrusive in relation to the behavior being addressed. (See inserts highlighted above)

The author believes"excessively" should be defined. The level of behavioral concern – such as limiting these approaches to self-injury, aggression, or other serious behaviors with significant legal considerations, including serious property damage.

B. The proposed use of a controlled procedure must be ~~is~~ supported by documentation providing detailed descriptions of ~~describing~~ how intervention procedures incorporating positive approaches and less intrusive procedures have been tried, how long they were tried in each instance, and possible reasons why they were unsuccessful in controlling the behavior of concern.

C. The case manager obtains informed consent for implementing the procedure as specified in part 9525.2780 before the procedure is implemented, except when faradic shock is ordered by a court under part 9525.2730, subpart 3. (Recommend removing it as an option)

D. The proposed use of the procedure is reviewed and approved by the expanded interdisciplinary team as required by subpart 1a.

E. If the license holder is licensed under parts 9525.0215 to 9525.0355; 9525.1500 to 9525.1690; or 9525.2000 to 9525.2140, the proposed use of the procedure is reviewed and approved by an internal review committee that meets the requirements in subpart 2.

F. The procedure is implemented and monitored by staff members trained to implement the procedure. The license holder is responsible for providing ongoing training to all staff members responsible for implementing, supervising, and monitoring controlled procedures, to ensure that all staff responsible for implementing the program are competent to implement the procedures. The license holder must provide members of the expanded interdisciplinary team with documentation that staff are competent to implement the procedures. Controlled procedures must not be implemented as part of the individual program plan until staff who are

involved in providing supervision or training of the person have been trained to implement all programs contained in the individual program plan.

(The state needs to be making the requirements clear and uniform and not let the license holder drive training related to and implementation, oversight, and monitoring of these practices or procedures.)

G. Time out procedures must meet the following conditions:

(1) When possible, time out procedures must be implemented in the person's own room or other area commonly used as living space rather than in a room used solely for time out.

(2) When possible, the person must be returned to the activity from which the person was removed when the time out procedure is completed.

(3) Persons in time out must be continuously monitored by staff.

(4) Release from time out is contingent on the person's stopping or bringing under control the behavior that precipitated the time out and must occur as soon as the behavior that precipitated the time out abates or stops. If the precipitating behavior has not abated or stopped, staff members must attempt to return the person to an ongoing activity at least every 30 minutes.

(This sounds like seclusion rather than time out)

(5) If time out is implemented contingent on repeated instances of the target behavior for longer than 30 consecutive minutes, the person must be offered access to a bathroom and drinking water.

(6) Placement of a person in room time out must not exceed 60 consecutive minutes from the initiation of the procedure.

(7) Time out rooms must:

(a) provide a safe environment for the person;

(b) have an observation window or other device to permit continuous visual monitoring of the person;

(c) measure at least 36 square feet and be large enough to allow the person to stand, to stretch the person's arms, and to lie down; and

(d) be well lighted, well ventilated, and clean.

H. Controlled procedures using manual restraint must meet the following conditions:

(1) The person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated. (Good)

(2) The person must be given an opportunity for release from the manual restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes.

(3) Efforts to lessen or discontinue the manual restraint must be made at least every 15 minutes, unless contraindicated. (Encourage – as soon as there is any hope of releasing – 15 minutes should be the clear maximum time).The time each effort was made and the person's response to the effort must be noted in the person's permanent record.

(4) The procedures must comply with other standards in parts 9525.2700 to 9525.2810.

(Please see earlier comments)

I. Controlled procedures using mechanical restraint must meet the following conditions:

(1) The person's primary care physician must be consulted to determine whether implementing the procedure is medically contraindicated.

(2) Use of mechanical restraint that results in restriction of two or fewer limbs or that does not restrict the person's movement from one location to another requires the following procedures:

(a) Staff must check on the person every 30 minutes and document that each check was made.

(b) The person must be given an opportunity for release from the mechanical restraint and for motion and exercise of the restricted body parts for at least ten minutes out of every 60 minutes that the mechanical restraints are used.

(c) Efforts to lessen or discontinue the mechanical restraint must be made at least every 15 minutes. The time each effort was made and the person's response to the effort must be noted in the person's permanent record.

(3) Use of mechanical restraint that results in restriction of three or more of a person's limbs or that restricts the person's movement from one location to another must meet the conditions of subitems (1) and (2) and the following additional conditions:

(a) Efforts to lessen or discontinue the mechanical restraint must be made at least every 15 minutes. The time each effort was made and the person's response to the effort must be noted in the person's permanent record.

(b) A staff member shall remain with a person during the time the person is in mechanical restraint and shall take the action specified in unit (a).

(4) The procedures must comply with other standards in parts 9525.2700 to 9525.2810.

(Please see earlier comments. Severe limitations need to be in place if this is not eliminated.)

Subp. 1a. **Review and approval by expanded interdisciplinary team**. When an individual program plan proposes using a controlled procedure, or when a substantial change is proposed, the plan must be reviewed and approved by the expanded interdisciplinary team.

Subp. 2. **Review and approval by internal review committee**. A license holder licensed under parts 9525.0215 to 9525.0355, 9525.1500 to 9525.1690, or 9525.2000 to 9525.2140, must have at least one committee that reviews all individual program plans proposing the use of controlled procedures. The administrator with overall responsibility for the license holder's policy and program shall appoint the committee. Before approving a plan, the committee shall determine if each plan as submitted meets the requirements of parts 9525.2700 to 9525.2810 and all other applicable requirements governing behavior management established by federal regulations or by order of a court. The internal review committee membership must meet the criteria in items A and B.

A. The internal review committee must include two individuals employed by the license holder as staff members or consultants. One of the two individuals must be a qualified mental retardation professional with at least one year of direct experience in assessing, planning, implementing, and monitoring behavior intervention programs.

(The author believes this is insufficient education/experience/qualifications for this level of responsibility.

B. At least one-third of the committee members must be individuals who have no ownership or controlling interest in the facility and who are not employed by or under contract with the facility in any other capacity besides serving on the committee. This component of the committee membership must include at least one parent or guardian of a person with mental retardation or a related condition.

Subp. 2a. **Quarterly reporting**. The license holder must submit data on the use and effectiveness of individual program plans that incorporate the use of controlled procedures identified in subpart 4 to the expanded interdisciplinary team members, the internal review committee, and the regional review committee. The data must be submitted quarterly on forms prescribed by the commissioner. The case manager shall ensure that this information is submitted as required under this subpart.

(Again, why wait for quarterly if the Regional Review Committee might see a problem or opportunity to provide support to the provider, etc. it will be missed for potentially 90 days)

Subp. 4. **Submission of individual program plan to regional review committee**. Within ten calendar days of the date that a controlled procedure in items A to D is approved under subpart 2, or a substantial change is made, the case manager shall ensure the regional review committee receives a copy of the individual program plan sent by the license holder, that proposes the procedure or that portion of the individual program plan that contains the substantial change, regarding implementation of the following controlled procedures:

(This review should occur before the plan goes into effect – not after)

A. manual restraint;
B. mechanical restraint;
C. use of a time out procedure for 15 minutes or more at one time or for a cumulative total of 30 minutes or more in one day; or
D. faradic shock.

9525.2760 REQUIREMENTS FOR INDIVIDUAL PROGRAM PLANS PROPOSING USE OF A CONTROLLED PROCEDURE.

Subpart 1. **Requirements**. An individual program plan that includes the use of a controlled procedure must contain the information specified in subparts 2 to 6.

Subp. 2. **Assessment information**. When an expanded interdisciplinary team is developing an individual program plan that includes the use of a controlled procedure, the case manager must obtain assessment information that includes the elements specified in items A to F:

A. a physical and psychological description of the person;

B. a report completed by the person's primary care physician within 90 days before the initial development of the individual program plan that includes the use of a controlled procedure and indicates that the physician has reviewed whether there are existing medical conditions that:

(90 days before is excellent – but also need to engage the medical practitioner as soon as an emergency happens).

(1) could result in the demonstration of behavior for which a controlled procedure might be proposed; or

(2) should be considered in the development of a program for the person;

C. a baseline measurement of the behavior to be increased and the target behavior for decrease or elimination that provides a clear description of the behavior and the degree to which it is being expressed, with enough detail to provide a basis for comparing the behaviors to be increased and decreased before and after use of the proposed controlled procedure;

D. a summary of what has been considered or attempted to change elements in the person's environment, including the physical and social environment, that could be influencing the person's behavior, including an analysis of the person's current residence and day program and specifically addressing the question of whether a change in these services appears to be warranted;

E. an analysis of to what extent the behavior identified for reduction or elimination represents an attempt by the person to communicate with others or serves as a means to control the person's environment and recommendations for changes in the person's training program or environment that are designed to enhance communication; and

F. a summary of previous interventions used to modify the target behavior and of the factors believed to have interfered with the effectiveness of those interventions.

The information in items A to F must be retained in the person's permanent record for at least five years after implementing a controlled procedure.

Subp. 4. **Review and content standards**. An individual program plan that proposes the use of controlled procedures must include the following elements:

A. objectives designed to develop or enhance the adaptive behavior of the person for whom the plan is made, including the change expected in the target behavior and the anticipated time frame for achieving the change;

B. objectives designed to reduce or eliminate the target behavior of the person for whom the plan is made, including the change expected in the adaptive behavior and the anticipated time frame for achieving the change;

C. strategies to increase aspects of the person's behavior that provide an alternative functional adaptive replacement behavior to the behavior identified for reduction or elimination, including when and under what circumstances the procedure will be used;

D. strategies to decrease aspects of the person's target behavior, including when and under what circumstances the procedure will be used;

E. the projected starting date and completion date for achievement of each objective;

F. a detailed description of the ways in which implementation of the procedure will be monitored, by whom, and how frequently, specifying how staff implementing the procedure will be trained and supervised and ensuring that direct on-site supervision of the procedure's implementation is provided by the professional staff responsible for developing the procedure;

(The state needs to spell out the policy and then hold the license holders to it. Too little structure here)

G. a description of any discomforts, risks, or side effects that it is reasonable to expect;

H. a description of the data collection method used to evaluate the effectiveness of the proposed procedures and to monitor expected or unexpected side effects;

(The state needs to spell out the policy and then hold the license holders to it. Too little structure here)

I. a description of the plan for maintaining and generalizing the positive changes in the person's behavior that may occur as a result of implementing the procedure;

J. a description of how implementation of the plan will be coordinated with services provided by other agencies or documentation of why the plan will not be implemented by a particular service provider or in a particular setting;

K. a description of how implementation of the plan involves families and friends; and

L. the date when use of the controlled procedure will terminate unless, before that date, continued use of the procedure is approved by the case manager and the member of the expanded interdisciplinary team who is a qualified mental retardation professional with at least one year of experience in assessing, planning, implementing, monitoring, and reviewing behavior management programs. The projected termination date must be no more than 90 days after the date on which use of the procedure was approved. Reapproval for using the procedure must be obtained at 90-day intervals, if evaluation data on the target behavior and effectiveness of the procedure support continuation.

Subp. 5. **Monitoring individual program plan**. Monitoring the proposed controlled procedure must be completed as adopted in the individual program plan and in accordance with Minnesota Statutes, section 256B.092, subdivision 1c.

(This should be explicitly stated here and strongly controlled.)

Subp. 6. **Documenting informed consent**. Except in situations governed by part 9525.2730, subpart 3 or 9525.2770, evidence that informed consent has been obtained from a person or individual authorized to give consent must be added to the person's individual program plan before a controlled procedure is implemented.

9525.2770 EMERGENCY USE OF CONTROLLED PROCEDURES.

Subpart 1. **General requirement**. Implementing a controlled procedure without first meeting the requirements of parts 9525.2750, 9525.2760, and 9525.2780 is permitted only when the emergency use criteria and requirements in subparts 2 to 6 are met.

Subp. 2. **Criteria for emergency use.** Emergency use of controlled procedures must meet the conditions in items A to C.

A. Immediate intervention is needed to protect the person or others from physical injury or to prevent severe property damage that is an immediate threat to the physical safety of the person or others.

B. The individual program plan of the person demonstrating the behavior does not include provisions for the use of the controlled procedure.

C. The procedure used is the least intrusive intervention possible to react effectively to the emergency situation.

Subp. 5. **Written policy**. The license holder must have a written policy on emergency use of controlled procedures that specifies:

(The state needs to spell out the policy and then hold the license holders to it. Too little structure here = no accountability)

A. any controlled procedures that the license holder does not allow to be used on an emergency basis;

B. the internal procedures that must be followed for emergency use, including the procedure for complying with subpart 6;

C. how the license holder will monitor and control emergency use;

(See above comment)

D. the training a staff member must have completed before being permitted by the license holder to implement a controlled procedure under emergency conditions;

(See above comment)

E. that the standards in part 9525.2750, subpart 1, items F, G, subitems (1) to (5), H, and I, must be met when controlled procedures are used on an emergency basis; and

F. use of a controlled procedure initiated on an emergency basis according to subpart 4 must not continue for more than 15 days.

(This is far too long without formal approval.)

Subp. 6. **Reporting and reviewing emergency use**. Any emergency use of a controlled procedure by a license holder governed by parts 9525.2700 to 9525.2810 must be reported and

reviewed as specified in items A to E. A license holder shall designate at least one staff member to be responsible for reviewing, documenting, and reporting use of emergency procedures. The designated staff member must be a QMRP.

A. Within three calendar days after an emergency use of a controlled procedure, the staff member who implemented the emergency use shall report in writing to the designated staff member the following information about the emergency use:

(This is far too long. 24 hours is the maximum it should be allowed to wait)

(1) a detailed description of the incident leading to the use of the procedure as an emergency intervention;

(2) the controlled procedure that was used;

(3) the time implementation began and the time it was completed;

(4) the behavioral outcome that resulted;

(5) why the procedure used was judged to be necessary to prevent injury or severe property damage; and

(6) an assessment of the likelihood that the behavior necessitating emergency use will recur.

B. Within seven calendar days after the date of the emergency use of a controlled procedure, the designated staff member shall review the report prepared by the staff member who implemented the emergency procedure and ensure the report is sent to the case manager and expanded interdisciplinary team for review. If the emergency use involved manual restraint, mechanical restraint, or use of exclusionary time out exceeding 15 minutes at one time or a cumulative total of 30 minutes or more in a 24-hour period, the designated staff member must ensure the report is sent to the internal review committee within seven calendar days of the emergency use of the controlled procedure.

(Too much "internal" review here creates opportunities for abuse. Need more external involvement.)

C. Within seven calendar days after the date of receipt of the emergency report in item A, the case manager shall confer with members of the expanded interdisciplinary team to:

(1) discuss the incident reported in item A to:

(a) define the target behavior for reduction or elimination in observable and measurable terminology;

(b) identify the antecedent or event that gave rise to the target behavior; and

(c) identify the perceived function the target behavior served; and

(2) determine what modifications should be made to the existing individual program plan so as to not require the use of a controlled procedure.

D. An expanded interdisciplinary team meeting must be conducted within 30 calendar days after the emergency use if it is determined that a controlled procedure is necessary and that the target behavior should be identified in the individual program plan for reduction or elimination.

(This appears to be designed to discourage and/or reduce the likelihood of any real challenge to those who use the intervention …or are proposing the intervention)

E. The emergency use of a controlled procedure as well as changes made to the adaptive skill acquisition portion of the plan must be incorporated in the individual program plan within 15 calendar days after the expanded interdisciplinary team meeting required under this part. During this time, the designated staff member shall document all attempts to use less restrictive alternatives including:

(1) adaptive skill acquisition procedures currently being used and why they were not successful;

(2) attempts made at less restrictive procedures that failed and why they failed; and

(3) rationale for not attempting the use of other less restrictive alternatives.

The designated staff member must ensure a copy of the report required under item A is sent to the internal review committee and the regional review committee within five working days after the expanded interdisciplinary team meeting.

F. A summary of the interdisciplinary team's decision under items C and E must be added to the person's permanent record.

9525.2790 REGIONAL REVIEW COMMITTEES.

Subpart 1. **Appointment**. As mandated by Minnesota Statutes, section 245.825, the commissioner shall initially appoint at least two regional review committees to monitor parts 9525.2700 to 9525.2810. The commissioner shall establish additional committees if required by the number of procedures received for review and the level of effort required to ensure timely and thorough review.

Subp. 2. **Membership**. Each regional review committee must include:

A. at least one member who is licensed as a psychologist by the state of Minnesota and whose areas of training, competence, and experience include mental retardation and behavior management; and

(It seems that people who are competent to challenge the position of needing a restrictive intervention need to be a majority of this group)

B. representation from each of the following categories:

(1) license holders governed by parts 9525.2700 to 9525.2810;

(2) parents or guardians of persons with mental retardation or a related condition;

(3) other concerned citizens, none of whom is employed by or has a controlling interest in a program or service governed by parts 9525.2700 to 9525.2810; and

(4) the department.

When a matter being reviewed by the committee requires the expertise and professional judgment of a medical doctor, the commissioner shall make the services of a licensed physician available to the committee.

Subp. 3. **Duties and responsibi**lities. Regional committees shall:

A. meet at least quarterly to review the reports on use of time out, mechanical restraint, and manual restraint required by parts 9525.2750 and 9525.2770 and act on those reports according to procedures established by the commissioner;

(Quarterly seems too infrequent to be of any significant assistance to make effective change)

B. meet or confer as necessary if a case manager requests the authorization required in part 9525.2740, subpart 2; and

C. act as directed by the commissioner to:

(1) monitor and facilitate compliance with parts 9525.2700 to 9525.2810 and make recommendations to the commissioner;

(2) provide technical assistance in achieving compliance; and

(3) review, monitor, and report to the commissioner on statewide use of aversive and deprivation procedures in relationship to the use of less intrusive alternatives and to the use of psychotropic medication.

(2 and 3 are important functions and must be actively and overtly engaged in at all times)

9525.2800 REPORTING NONCOMPLIANCE.

Subpart 1. **Required reporting**. Unauthorized use of aversive and deprivation procedures is subject to the requirements of Minnesota Statutes, sections 626.556 and 626.557, which govern reporting of maltreatment of minors and vulnerable adults. For purposes of parts 9525.2700 to 9525.2810, "unauthorized use of an aversive or deprivation procedure" means:

A. a procedure that is restricted or prohibited under part 9525.2730, subparts 1 and 3; and

B. procedures that have not been authorized as required under part 9525.2740, subpart 2.

Individuals are designated as mandated reporters according to Minnesota Statutes, sections 626.556, subdivision 3, and 626.557 , subdivision 3.

Subp. 2. **Voluntary reporting**. If an individual who is not mandated to report by Minnesota Statutes, section 626.556, subdivision 3 or 626.557, subdivision 3, has reason to believe that a license holder governed by parts 9525.2700 to 9525.2810 is not in compliance with parts 9525.2700 to 9525.2810, the concern or complaint may be reported as described in items A and B.

A. Compliance-related concerns or complaints about any license holder governed by parts 9525.2700 to 9525.2810 can be reported to: The Department of Human Services, Division of Licensing, 444 Lafayette Road, Saint Paul, Minnesota 55155.

B. Compliance-related concerns or complaints about nursing homes to which parts 9525.2700 to 9525.2810 apply or about intermediate care facilities for persons with mental

retardation or a related condition may be reported both to the commissioner under item A and to: The Minnesota Department of Health, Office of Health Facility complaints, 717 Delaware Street S.E., Minneapolis, Minnesota 55440.

9525.2810 PENALTY FOR NONCOMPLIANCE.

If a license holder governed by parts 9525.2700 to 9525.2810 does not comply with parts 9525.2700 to 9525.2810, the commissioner has the authority to take enforcement action pursuant to Minnesota Statutes, chapter 245A and section 252.28, subdivision 2.

("Can take enforcement action" does not clearly communicate that enforcement will occur.)

A Summary of *National Review of Restraint Related Deaths of Children and Adults with Disabilities: The Lethal Consequences of Restraint*

In the document *National Review of Restraint Related Deaths of Children and Adults With Disabilities: The Lethal Consequences of Restraint* published by Equip for Equality (Illinois Protection and Advocacy Agency) in 2011, they point out that restraint, even in emergencies,

> "remains one of the most controversial and dangerous measures used today in settings that provide services to people with disabilities. Restraint is an intrusive and dangerous intervention that can have significant adverse implications for the physical and emotional well-being of the individual who is restrained. The use of restraints continues to represent a significant risk to adults and children with… developmental disabilities in any setting where restraints are used, as evidenced by the growing number of documented deaths."

The problems associated with restraint, even in emergencies, are many. The *National Review* continues:

> "The risk that restraint poses to people with disabilities is heightened by an oversight system that remains seriously flawed…The total number of children and adults, including seniors, who die each year as a result of being put in restraints, is unknown."

In the 14 years since the original report in a 1998 investigative series in the Hartford Courant, there is still no comprehensive oversight system in place in the majority of the states nor at the national level for monitoring restraint usage and compliance with the law.

This is critical to address in Minnesota at this time to prevent "emergencies" from becoming life threatening to the individuals upon whom restraints are utilized to prevent injury. While the number of people who have died as a result of being put into restraints is unknown, the report carefully reviewed 61 cases of death following a restraint and came up with the following analysis.

1. The restraints implemented in one-third of the cases…failed to meet the legal standard for use of restraint.

2. Of those who were restrained to address "aggressive behavior," nearly half either did not meet the prevailing legal standard to be restrained, imminent risk of harm to self or others, or a determination as to whether the legal standard was met could not be made from the treatment/medical records.

3. In nearly all cases where information on less restrictive interventions could be found, the staff failed to use all available interventions. Most cases did not include documentation as to why other less restrictive measures failed.

In the majority of deaths, unsafe and inappropriate restraint methods were utilized.

1. Of the 69 dangerous practices identified, 54% involved a person lying face down in a prone position, which is associated with increased risk of asphyxia and aspiration (despite distinct prohibitions against such procedures in virtually every state – comment added); 51% involved a person lying face-up in the supine position without the person's head being elevated, which is associated with increased risk of asphyxia, fatal cardiac arrhythmia or respiratory arrest; and 44% involved staff exerting pressure to the person's neck or torso, creating a high risk of fatality.

2. Only 7% of the cases involved the use of techniques deemed appropriate by standards for managing a person's aggressive behavior.

Equally disturbing are the responses of the staff, who are supposedly trained to be able to provide safe restraint in an emergency situation. The *National Review* also found:

1. Forty-four percent (27 of 61 cases) of the individuals were discovered to have died while in mechanical or physical restraint.

2. Forty-three percent (12 of 28 cases) of the cases with available information documented that the individual restrained indicated verbally or nonverbally to staff that he or she was in physical distress prior to death. The staff responded to the person's indication of physical distress in only half of these cases. Yet even when staff responded, the individuals died.

3. In the majority of cases, the staff noticed signs of distress prior to the person's death. In three cases, the first signs of physical distress were noted before the person was even placed in restraints.

4. Delay in staff's recognition and response to the person's distress or death was evident in 63% (34 of 54) of the cases with available information.

The factors that were most frequently noted to have contributed directly or indirectly to the person's death included the following:

1. Pre-existing medical conditions (67%, or 41 cases).
2. Insufficient monitoring by the staff (62%, or 38 cases).
3. Inadequate response by the staff to the person's distress (49%, or 30 cases).
4. Overuse of force in physically restraining the person (39%, or 24 cases).
5. Physical restraint not correctly done (34%, or 21 cases).
6. Failure to use any other less intrusive interventions before restraining the person (25%, or 15 cases).

A Summary of Positive Behavior Supports (PBS). *What is PBS?*

PBS uses systemic and individualized strategies to prevent problem behavior and achieve positive social and learning outcomes. It integrates valued outcomes, human behavioral science, validated procedures, and systems change to enhance quality of life and reduce problem behavior. Its primary goal is to improve the link between research-validated practices and the environments in which teaching and learning occurs.

This behaviorally-based systems approach enhances the capacity of service and support communities to design effective teaching and learning environments that improve lifestyle results (personal, health, social, family, work, recreation, etc.). These environments apply contextually and culturally appropriate interventions to make problem behavior less effective, efficient, and relevant, and to make desired behavior more functional (Sugai et al., 2000).

PBS is rooted in the theory of applied behavioral analysis, but it extends well beyond this technology and is more comprehensive. It is a proactive, problem-solving, data-based approach that unmasks and eliminates the underlying causes of problem behavior. PBS is less concerned with symptoms and more with underlying causes.

The goals of preventing or reducing problem behavior are reached by changing the policies and practices, by altering the environment, and by teaching new skills to the individual and staff.

Research has established the efficacy of PBS with individual with IDD. Carr et al. (1999) synthesized over 100 research studies published between the years of 1985 and 1996 to investigate the behavioral outcomes for the 230 individuals with problem behavior who were part of their database.

Carr and his colleagues concluded that PBS was successful in achieving at least an 80% reduction in problem behavior for approximately two-thirds of the behavioral outcomes that were studied. PBS is also being extended beyond intervention with individual participants, for much of the current PBS research is focused on evaluating the use of PBS for organization-wide applications.

In an effort to consolidate the developing learning, thinking and practice involved in supporting people with severe and multiple disabilities in the community, the Community Integration Project (1986) identified features common to positive interventions:

1) attempts to understand the meaning a behavior has for a person;
2) offers the person a positive alternative;
3) utilizes non-intrusive techniques; and
4) offers strategies which have been validated and are intended to be used in integrated community settings.

In a 1990 review, Robert Horner and colleagues from across the U.S. coined the phrase "Positive Approaches" to encompass a range of theoretical and practical approaches --

educational programming, positive programming, functional communication training, gentle teaching, functional equivalence programming, and nonaversive behavior management.

Together these approaches develop an array of approaches for supporting people with challenging behaviors, placing an emphasis on an ethical standard which maintains and supports the personal dignity of the individual, and recommend prohibition and/or restrictions on aversive approaches.

Horner identified nine common themes in positive technology.

- An emphasis on lifestyle change -- Behavioral support should result in durable, generalized changes in the way an individual behaves, and these changes should affect the individual's access to community settings, to social contact, and to a greater array of preferred events.

- Functional analysis -- Assessing the antecedents and consequences of a behavior and building a direct link between the results from a functional analysis and the actual intervention program that is developed.

- Multicomponent interventions -- Movement of an individual to a more personal, less segregated setting, ignoring minor inappropriate behaviors, providing multiple opportunities for choice making, systematic instruction on new functional behaviors, increased access to preferred events, and staff training may all be combined into one intervention plan.

- Manipulation of ecological and setting events – For instance, diet, eating schedule, exercise options, sleeping patterns, rapport, noise level, density of housing, and predictability of daily events are being recognized as nontrivial variables in both the quality of a person's life and the extent to which undesirable behaviors are manifested.

- Emphasis on antecedent manipulations -- This emphasis comes in such forms as (a) modifying events in a setting so that the stimuli eliciting the undesirable behavior are reduced or removed and (b) adding antecedent events that increase the likelihood of positive behaviors.

- Teaching adaptive behavior -- This approach focuses on defining the behavioral "function" of challenging behaviors and teaching the individual socially acceptable ways of achieving that function. Among the most common examples is the teaching of communication skills.

- Building environments with effective consequences -- Nonaversive systems include traditional procedures of consistently rewarding positive behavior and reducing rewards for undesirable behavior.

- Eliminating the use of punishment -- A general theme of the positive programming approach is that the delivery of punishers for challenging behaviors is not desirable. The most common alternative is to minimize the reinforcement of challenging behaviors, redirect the person to more appropriate behaviors, and combine this procedure with other instructional and environmental manipulations. Many advocates of positive behavior management recognize, however, that a typical array of events (frowns, reprimands, etc.) can be viewed technically as punishers and yet provide critical learning information.

- Distinguish emergency procedures from proactive programming -- An effective technology of positive behavioral support must include specific procedures for providing support in dangerous situations. It is critical, however, that a clear distinction be made between crisis intervention strategies for infrequent use in emergency situations and ongoing proactive programming designed to produce substantive positive change. (Horner et al, 1990, 127-128).

Some resources that exist to assist with the process of developing a truly mature and competent Positive Behavior focused support system include the Rehabilitation Research and Training Center (RRTC) on Positive Behavior Support, the *Journal of Positive Behavior Interventions*, and the Association for Positive Behavior Support (APBS).

Some of the most important elements of effective PBS involves creating the appropriate support and learning environment.

Specifically, we must collectively work to minimize random stressors, aversive events and stimuli, opportunities to aggress and to be victimized, destabilizing factors (including neglected health care), and negative role model exposure.

Simultaneously we must also maximize identification with positive role models, positive self-esteem and self-image, internalization of socially valid rules of conduct/pro-social skills, empathic response skills, recognition of thinking errors,
escaping negative situations, dealing with dilemmas, confusion, and pain, among others.

For this to be successful, it is generally agreed that there are some necessary conditions. These include comprehensive staff training, consistent staff interactions, quality "clinical supervision" for staff, and well developed person centered plans, including positive behavior support plans and safety plans.

A comprehensive positive behavior support plan should include, at a minimum:

1) Strategies to improve the overall lifestyle of the person;

2) Strategies to address things that "set the person up" to have trouble,
3) Strategies to address things that "set the person off,"
4) Strategies to teach new skills, such as problem solving,
5) Strategies to teach new ways to communicate,
6) Strategies to improve coping skills,
7) Rewards for appropriate behavior,
8) A minimization of rewards for inappropriate behavior,
9) Clear and simple directions for staff, and
10) Strategies for damage control.

Following are a few techniques which are generally considered positive for increasing behavior, and which should be acceptable in any rule revision:

- Positive Reinforcement
- Modeling
- Forward and backward chaining
- Verbal, gestural, and very brief and gentle physical prompting which provides cues which help to initiate the desired behavior or skill
- Fading
- Shaping

Some informal positive support strategies to address problem behaviors include:

- Eliminate things likely to cause or lead up to the behaviors,
- Eliminate negative staff interactions - especially power struggles,
- Remove unnecessary demands and requests,
- Change location and timing of activities,
- Rearrange the environment,
- Gentle teaching,
- Interrupt the behavior with distraction or redirection,
- Adjust proximity,
- Insert situation appropriate humor,
- Instructional control,
- Communication/conversation, and
- Relaxation and stress management,

Some formal techniques that can be used as positive behavior supports

- Differential Reinforcement of Alternative Behavior – DRA. The reinforcement of those behaviors which are incompatible with the undesired response in intensity, duration, or topography.

- Differential Reinforcement of Low Rates of Responding – DRL. The reinforcement of the undesired response only if at least a specified period of time has elapsed since the last

response, or only if fewer than a specified number of the undesired responses occurred during a preceding interval of time.

- Differential Reinforcement of Other Behavior – DRO. The reinforcement after a specified period of no undesired responding. An alternate is the Differential Reinforcement of Other Behavior Progressive Schedule (DROP) which includes a progressively increased schedule of reinforcement.

- Stimulus Change. The non-contingent and sudden addition of a novel stimulus or an alteration of the incidental stimulus conditions.

- Program Supports. An instructional sequence designed to help the person reach certain behavioral objectives based on a functional analysis and involving the systematic manipulation of stimulus conditions, consequences, instructional stimuli, and other variables that have a functional relationship with the behavior.

The above section is taken from materials previously developed and published by the author of this report.

References and Resources:

American Psychiatric Association, American Psychiatric Nurses Association, and the National Association of Psychiatric Health Systems, *Learning from Each Other: Success Stories and Ideas for Reducing Restraint/Seclusion in Behavioral Health* (January, 2003).

Anderson, C. M., & Freeman, K. A. (2000). Positive behavior support: Expanding the application of applied behavior analysis. The Behavior Analyst, 23, 85-94.

Bennington-Davis, M. and Murphy, T., *Eliminating Seclusion and Restraint*, 32 Clinical Psychiatry News 12 (2004).

Bisek, D., *Scott Lawson v. Monroe County - A Lesson Learned*, The Mutual Effort, Vol. 4.3 (Summer, 1999) p. 1.

Bluebird, G., *Redefining the Roles of Consumers: Changing Culture and Practice in Mental Health Settings*, 42 Journal of Psychosocial Nursing and Mental Health Services 9 (2004) pp. 46-53.

Carr, E.G.; Horner, R.H.; Turnbull, A.P. et al. (1999). Positive behavior support for people with developmental disabilities: Research synthesis American Association on Mental Retardation Monograph Series. Washington, D.C.: American Association on Mental Retardation.

Carr, J. E., & Sidener, T. M. (2002). *On the relation between applied behavior analysis and positive behavioral support.* The Behavior Analyst, 25, 245-253.

Community Integration Project (1986a) A list of resources on positive interventions for severe behavior problems. Center on Human Policy: Syracuse University.

Community Integration Project (1986b) Characteristics of integrated Community-based Programs for People with Challenging Behaviors. Center on Human Policy: Syracuse University.

Civil Rights of Institutionalized Persons Act, 42 U.S.C. §1997 et seq.

Donnellan, A.M.; LaVigna, G.W.; Negri-Shoultz, N., et al. (1988) Progress without punishment: Effective approaches for learners with behavior problems. (1988) New York: Teachers College Press.

Fisher, W., *Restraint and Seclusion: A Review of the Literature*, 151 American Journal of Psychiatry 11 (1994) pp. 1584-1591.

Fisher, W., *Elements of Successful Restraint and Seclusion Reduction Programs and Their Application in a Large, Urban State Psychiatric Hospital*, 9 J. of Psychiatric Practice 1 (2003) pp. 7-15.

Hardenstine, B., *Leading the Way Toward a Seclusion and Restraint-Free Environment: Pennsylvania's Success Story*, Office of Mental Health and Substance Abuse Services, Pennsylvania Department of Public Welfare (2001).

Huckshorn, K.A., *Reducing Seclusion and Restraint Use in Mental Health Settings: Core Strategies for Prevention*, 42 Journal of Psychosocial Nursing and Mental Health Service 9 (2004) pp. 22-31.

Haimowitz, S., Urff, J., Huckshorn, A. (2006) Restraint and Seclusion: A Risk Management Guide. National Association of State Mental Health Program Directors http://www.nasmhpd.org/general_files/publications/ntac_pubs/R-S%20RISK%20MGMT%2010-10-06.pdf

Horner, R.H.; Dunlap, G., et al (1990) *Toward* a *Technology of "Nonaversive" Behavioral Support.* Journal of the Association for Persons with Severe Handicaps (JASH), 15, 3, 125-132.

Horner, R.H.; Sugai, G.; Todd, A.W. & Lewis-Palmer, T. (2005) *Schoolwide positive behavior support.* In L.M. Bambara & L. Kern (Eds.). Individualized supports for students with problem behaviors. New York: Guildford Press, pp. 359-390.

JCAHO Restraint and Seclusion Standards Effective January 1, 2001 http://ohanet.org/csr/resource/restraintseclusion.pdf

Kansas Institute of Positive Behavior Supports. www.kipbs.org

Mayer, M.A., Poindexter, A., Gabriel, E., Eds. (1997) Multi-Modal Self-Instruction Program Series on Mental and Behavioral Disorders in People Who Have Mental Retardation. TheraEd, Durham, NC.

Mayer, M.A., Chaney, A. and Gabriel, E. (1997) Introduction to Therapeutic Behavior Issues and Interventions. TheraEd, Durham, NC.

Mayer, M.A., Chaney, A. and Gabriel, E. (1997) Value Based Caregiving. TheraEd, Durham, NC.

Mayer, M.A., Chaney, A. and Gabriel, E. (1997) Introduction to Therapeutic Behavior Issues and Interventions. TheraEd, Durham, NC.

Mayer, M.A., Gabriel, E. (1997) Legal and Ethical Issues of Service Delivery. TheraEd, Durham, NC.

Mayer, M.A., McNelis, T. (1995). Program Design, Implementation, and Evaluation. In *Proceedings of the International Congress II on the Dually Diagnosed*, National Association for the Dually Diagnosed: Kingston, NY.

Moseley, Charles (2011) *Seclusion and Restraint*: A Brief Look at State Practices and Strategies, Joint Meeting of the Subcommittee on Safety and Services Subcommittee IACC, National Association of State Directors of Developmental Disabilities Services.

Protection and Advocacy, Inc., *Reforming Restraint and Seclusion Practices: An Advocacy Manual* (1992).

Morrison, L., Duryea, P., Moore, C., Nathanson-Shinn, A. (2002) *The Lethal Hazard of Prone Restraint: Positional Asphyxiation*. Protection and Advocacy, Inc.: Oakland, CA.

Scotty, J.R., Evans, I.M., Meyer, L.H., & Walker, P. (1991) *A Meta-Analysis of Intervention Research with Problem Behavior: Treatment Validity and Standards of Practice.* American Journal on Mental Retardation, 6(3), 233-56.

Seclusion and Restraint Practice Standards: A Review and Analysis. Mental Health America www.ncstac.org/index.php?option=com_content&view=article&id=94%3Aseclusion-and-restraint-practice-standards-a-review-and-analysis&catid=34&Itemid=53

Solomon, M.L., Jonikas, J.A., Cook, J.A., and Kerouac, J., *Positive Partnerships: How Consumers and Nonconsumers Can Work Together as Service Providers*, University of Chicago at Illinois (1998).

State DD Agency Policies on the Use of Restrictive Procedures The National Association of State Directors of Developmental Disabilities Services www.nasddds.org/RestrictiveProcedures/index.shtml (Primary research resource for state rules, policies, procedures, and staff training materials).

Substance Abuse and Mental Health Services Administration (SAMHSA*), Roadmap to a Restraint-Free Environment (2005)*, available at www.mentalhealth.samhsa.gov/publications/allpubs/sma06-4055

United States Code Federal Regulations: 42 U.S.C. Section 6009, Title 42

Chapter 75. Programs for Individuals with Developmental Disabilities.

Requirements for Long Term Care Facilities. Subpart I – Conditions of Participation for Intermediate Care Facilities for the Mentally Retarded (42CFR483.420; 440; 450).

Requirements for Long Term Care Facilities (42CFR483.13[a]). Resident behavior and facility practices. Restraints.

Weiss, E.M., Altimari, D., Blint, D.F., and Megan, K., *Deadly Restraint: A Nationwide Pattern of Death*, Hartford Courant (Oct. 11, 1998).

Wyatt v. Sitckney, 344 F.Supp.387 D.C. Ala (1972).