HEALTH LICENSING OFFICE

Kate Brown, Governor

Oregon Health Authority

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www.oregon.gov/OHA/HLO

WHO: **Health Licensing Office**
Behavior Analysis Regulatory Board
TELEPHONE CONFERENCE CALL ONLY
1430 Tandem Ave. NE, Suite 180 Salem, Oregon

WHEN: **9 a.m. Jan. 22, 2021**

In order to limit the exposure and spread of the COVID-19 virus and adhere to the Governor's social distancing measures the Health Licensing Office (Office) is prohibiting in-person attendance at the Board meeting. All audience members may attend the public meeting by telephone conference call. Conference call instructions are provided below.

What is the purpose of the meeting?
The purpose of the meeting is to conduct board business. A copy of the agenda is printed with this notice. Go to www.oregon.gov/OHA/HLO for current meeting information.

May the public attend a teleconference meeting?
Yes, however, non-board members are asked to **mute** the call.
Approximately five minutes prior to the start of the meeting:

- **Dial 1-877-336-1828 passcode 4111788** to be connected to the meeting. This phone line will stay connected for the duration of the meeting.
- The teleconference system will notify you that you are connected. For the record, Office staff will do a roll call of all audience members prior to and after the Executive Session.

Audience members are asked to send email to April Fleming at april.fleming@dhsoha.state.or.us stating they are logged into the telephone conference call and whether they want to make a comment during the public and interested parties feedback period.

What if the board/council enters into executive session?
Prior to entering executive session, the board/council chairperson will announce the nature of and the authority for holding executive session. Board members, designated participants such as staff, and representatives of the news media shall be allowed to attend the executive session. All other audience members are not allowed to attend the executive session. Executive session would be held according to ORS 192.660.

Representatives of the news media who are interested in attending an executive session are asked to contact April Fleming at april.fleming@dhsoha.state.or.us prior to the meeting to make arrangements to attend Executive Session by telephone conference call.

No final actions or final decisions will be made in executive session. The board/council will return to open session before taking any final action or making any final decisions.

Who do I contact if I have questions or need special accommodations?
The meeting location is accessible to persons with disabilities. A request for accommodations for persons with disabilities should be made at least 48 hours before the meeting. For questions or requests contact April Fleming at April.fleming@dhsoha.state.or.us

Item for Board Action

Approval of Agenda

Health Licensing Office
Behavior Analysis Regulatory Board

9 a.m. Jan. 22, 2021
TELEPHONE CONFERENCE CALL ONLY
1430 Tandem Ave. NE, Suite 180
Salem, Oregon

Call to order

1. **Item for Board action**
   - Approval of agenda

2. **Reports**
   - Director's report
   - COVID-19
   - Licensing and fiscal
   - Regulatory
   - Policy - discussion about restraints

3. **Item for Board action**
   - Vote to approve proposed rule and rule schedule

4. **Legislation**
   - Senate Bills 355 and 358 – Paul Terdal

5. **Public/interested parties' feedback**

6. **Executive session:** Pursuant to ORS 192.660(2)(f) and ORS 676.595 for the purpose of considering information exempt from public disclosure. (Cases)

7. **Item for Board action**
   - Vote on case(s)

8. **Other Board business**

Agenda is subject to change.
For the most up-to-date information, go to www.oregon.gov/OHA/PH/HLO

Revised

Director’s Report

COVID-19

Licensing and Fiscal Statistical Reports

Behavior Analysis Regulatory Board (BARB)

Report Date: **7-Jan-21**
(data as of most recently closed month to Report Date)

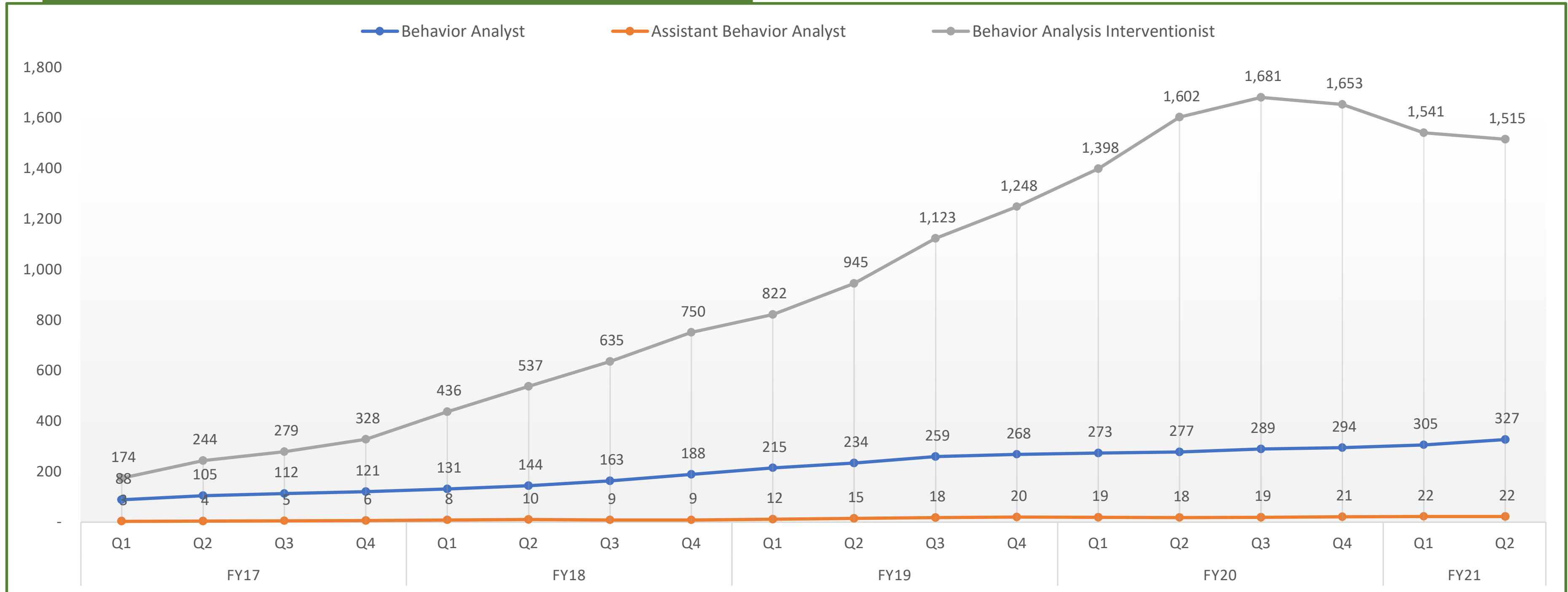
Licensing Statistics

Fiscal Year	Qtr	Behavior Analyst	Assistant Behavior Analyst	Behavior Analysis Interventionist	Total
			AUTHORIZATIONS ISSUED		
2019	**Q1**	33	3	169	205
	Q2	26	4	267	*297*
	Q3	36	1	249	*286*
	Q4	16	3	257	*276*
2020	**Q1**	21	1	328	*350*
	Q2	23	1	291	*315*
	Q3	24	4	214	*242*
	Q4	11	4	109	*124*
2021	**Q1**	35	1	200	*236*
	Q2	21	4	193	*218*
	Total:	246	26	2,277	*2,549*
			RENEWALS PROCESSED		
2019	**Q1**	28	5	70	*103*
	Q2	34	-	96	*130*
	Q3	52	2	100	*154*
	Q4	43	3	94	*140*
2020	**Q1**	42	4	128	*174*
	Q2	47	3	173	*223*
	Q3	71	2	138	*211*
	Q4	56	4	159	*219*
2021	**Q1**	55	7	227	*289*
	Q2	65	2	188	*255*
	Total:	493	32	1,373	*1,898*

Behavior Analysis Regulatory Board (BARB)

Report Date: **7-Jan-21**
(data as of most recently closed month to Report Date)

License Volume Trends *(averages by State Fiscal Year/Quarter)*

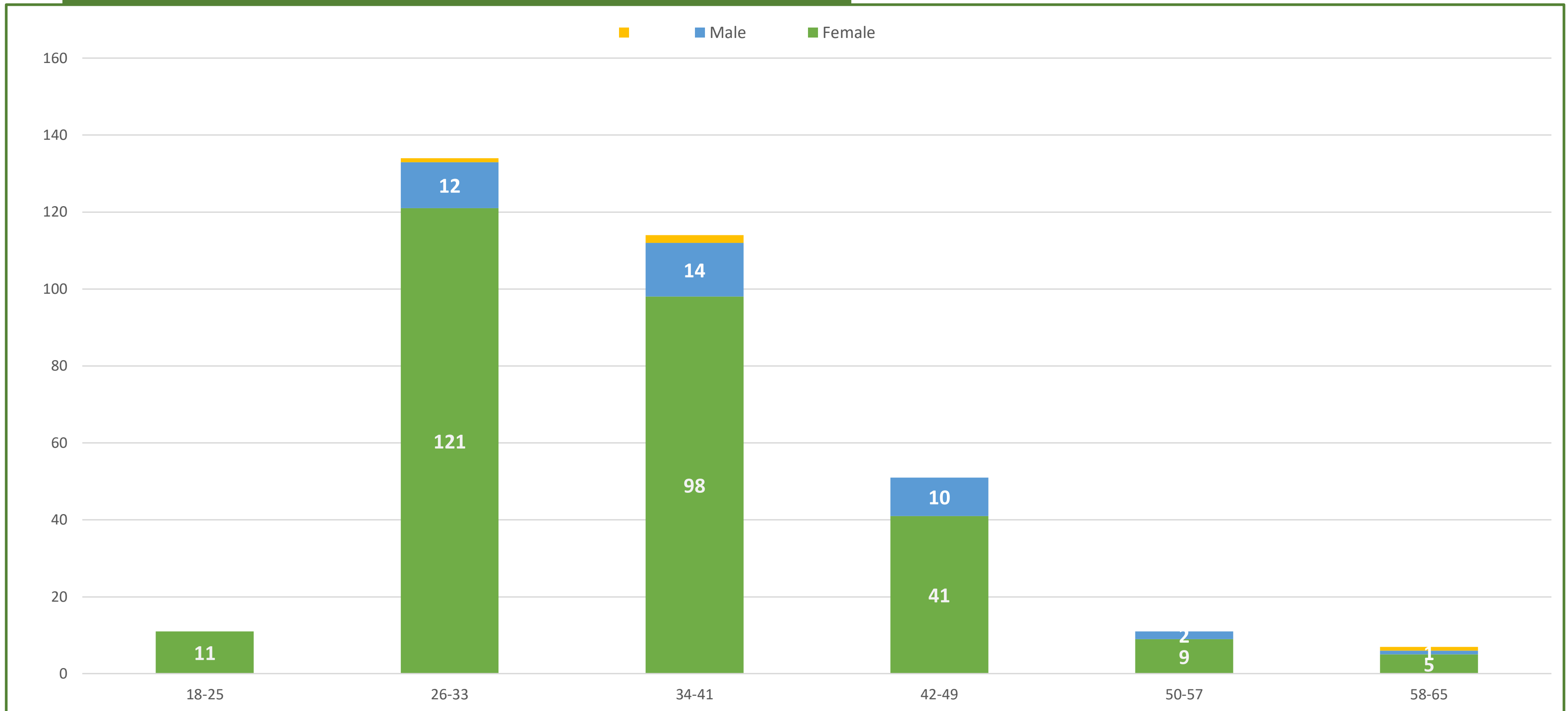


License Volume Trends Year-to-Year Growth Rate

State Fiscal Year	2017 (Jul16-Jun17)	2018 (Jul17-Jul19)	2019 (Jul18-Jun19)	2020 (Jul19-Jul20)	2021 (Jul20-Current*)
Behavior Analyst	68.1%	48.3%	54.3%	15.0%	12.0%
Assistant Behavior Analyst	8.2%	100.0%	82.2%	18.1%	15.8%
Behavior Analysis Interventionist	273.3%	133.5%	73.6%	51.6%	-2.7%

Behavior Analysis Regulatory Board (BARB)

Report Date: **7-Jan-21**
(data as of most recently closed month to Report Date)



Behavior Analysis Regulatory Board (BARB)

Report Date: **7-Jan-21**

(data as of most recently closed month to Report Date)

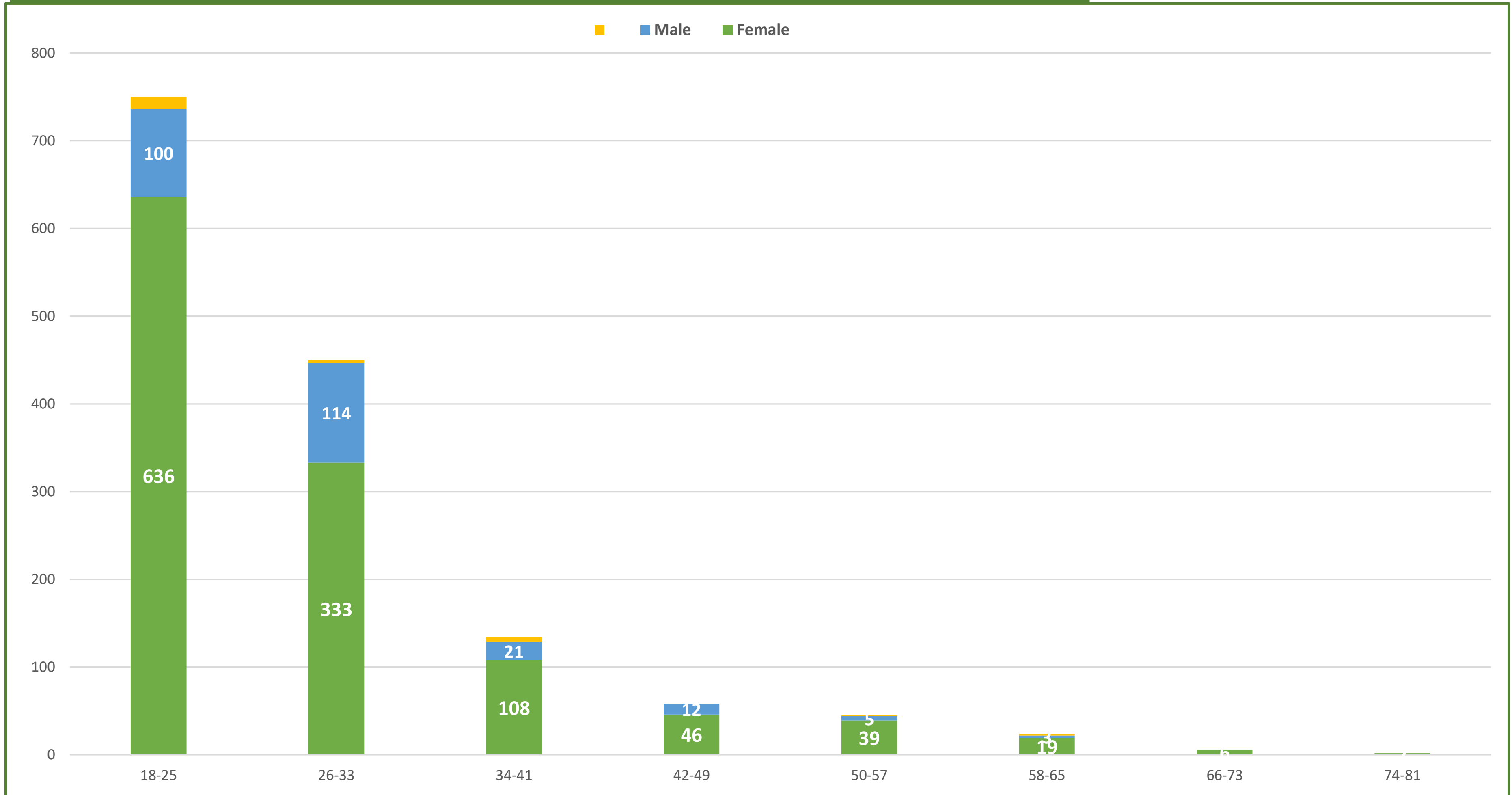
Active Asst Behavior Analysts - Grouped by Age and Gender

Behavior Analysis Regulatory Board (BARB)

Report Date: **7-Jan-21**

(data as of most recently closed month to Report Date)

Active Behavior Analysis Interventionist - Grouped by Age and Gender

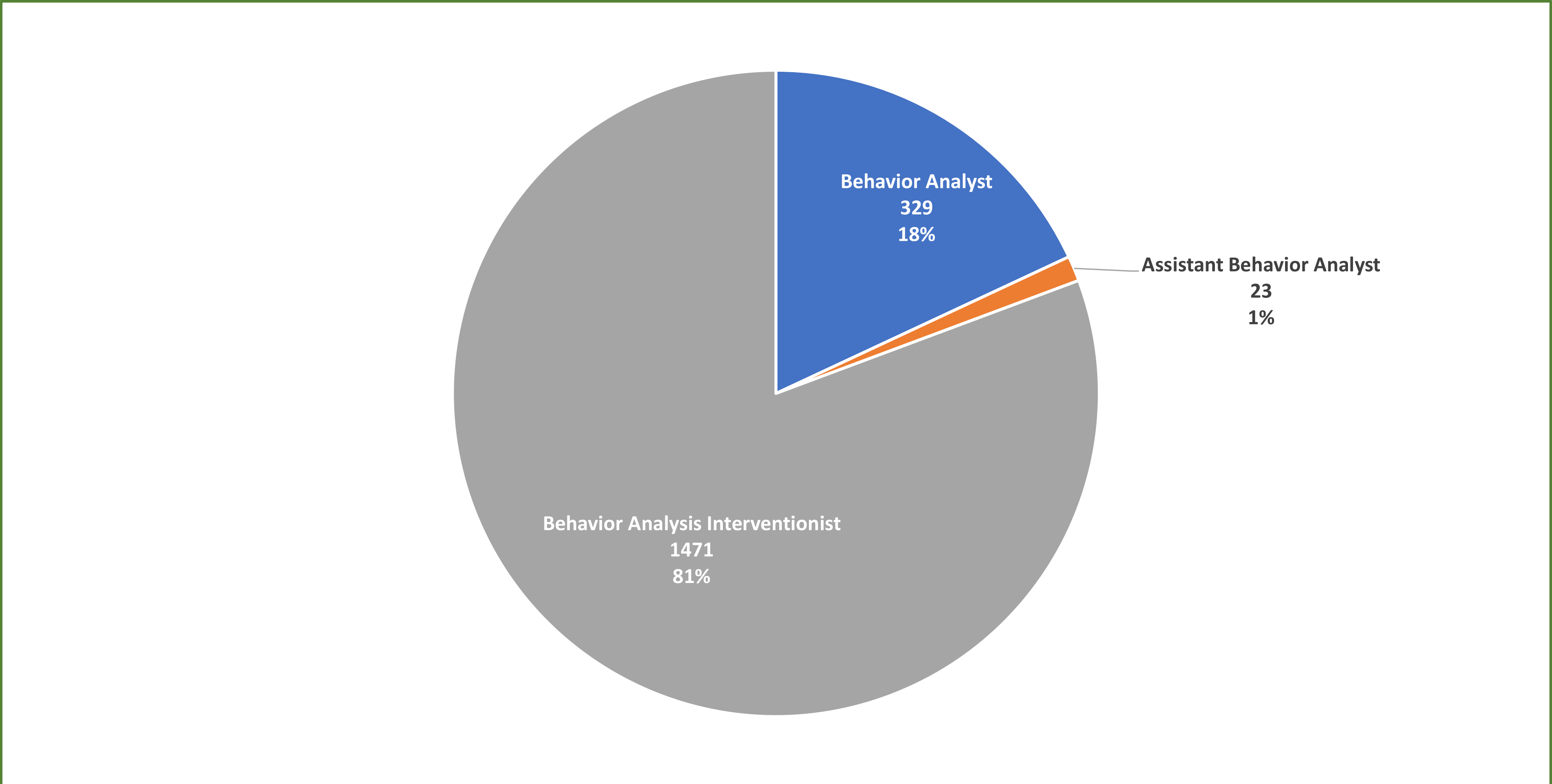


Behavior Analysis Regulatory Board (BARB)

Report Date: **7-Jan-21**

(data as of most recently closed month to Report Date)

License Volume by License Type



Behavior Analysis Regulatory Board (BARB)

Report Date: **7-Jan-21**
(data as of most recently closed month to Report Date)

Cash Flow by State Fiscal Year/Biennium

Biennium	*2017-19 >*		*2019-21 >*	
State Fiscal Year	**2018** *(Jul17-Jun18)*	**2019** *(Jul18-Jun19)*	**2020** *(Jul19-Jul20)*	**2021** *(Jul20-Current*)*
Beginning Cash Balance	$ 86,587	$ 220,301	$ 409,908	$ 557,337
Revenues	$ 181,810	$ 290,640	$ 311,757	$ 136,521
Expenditures	$ 48,096	$ 101,033	$ 164,328	$ 64,756
Net Operations *(Rev - Exp Only)*	*$ 133,714*	*$ 189,607*	*$ 147,429*	*$ 71,765*
Ending Cash Balance *(Beg Cash + Rev - Exp)*	$ 220,301	$ 409,908	$ 557,337	$ 629,101

HLO Pooled Expenditures Allocation Share for Board *(allocated based on average license volume and inspections/examinations counts)*

	2018	2019	2020	2021
Shared Assessment	0.400%	1.330%	1.759%	2.455%
Small Board	5.049%	9.426%	14.735%	17.970%
Examinations				
Inspections				

** As noted in header, to ensure consistency 'Current' data in all reports are based on data from the most recently closed month to the report date.*

Regulatory Report

HEALTH LICENSING OFFICE
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Behavior Analysis Regulatory Board

January 22, 2021

2017 – 2019 Biennium

Time Period:	Complaints Received:	Total Remaining Open:	Total Closed:
July 1 , 2017 through June 30, 2019	13	3	10

Complaints Received By:
Anonymous = 0
Clients = 1
Other = 12

2019 – 2021 Biennium

Time Period:	Complaints Received:	Total Remaining Open:	Total Closed:
July 1, 2019 through December 31, 2020	24	13	11

Complaints Received By:
Anonymous = 0
Clients = 1
Other = 23

Other: General Public, Internal, Licensees or Law Enforcement
Information as of: December 31, 2020

Policy

JOURNAL OF APPLIED BEHAVIOR ANALYSIS 2001, **34,** 501–504 NUMBER 4 (WINTER 2001)

THE DETRIMENTAL EFFECTS OF PHYSICAL RESTRAINT AS A CONSEQUENCE FOR INAPPROPRIATE CLASSROOM BEHAVIOR

SANDY K. MAGEE AND JANET ELLIS

UNIVERSITY OF NORTH TEXAS

Functional analyses produced inconclusive results regarding variables that maintained problem behavior for 2 students with developmental disabilities. Procedures were modified to include a contingent physical restraint condition based on in-class observations. Results indicated that under conditions in which physical restraint (i.e., basket-hold time-out) was applied contingent on problem behavior, rates of these behaviors increased across sessions for both subjects. Implications for the use of physical restraint in the classroom are discussed.

DESCRIPTORS: aggression, basket-hold time-out, functional analysis, physical restraint

Physical restraint is often used to manage severely disruptive classroom behavior. One form of physical restraint, called basket-hold time-out, involves confining the student in a chair or placing the student face down on the floor while restraining the student's arms. This form of physical restraint is used to protect the student or others or to punish problem behavior. Research findings on the basket-hold time-out indicate that it is effective in treating disruptive behavior (Grace, Kahng, & Fisher, 1994).

Nevertheless, the use of physical restraint could be problematic if the function of problem behavior is not identified. Because of the close physical contact required to implement the basket-hold procedure, restraint could function as a positive reinforcer for problem behavior that is maintained by attention from others. Likewise, physical restraint may result in escape or avoidance of aversive events due to its incompatibility with most academic task requirements. The misapplication of procedures (i.e., focusing on procedural form rather than on its behavioral effects) has been evaluated with other common interventions, such as planned ignoring (Iwata, Pace, Cowdery, & Miltenberger, 1994) and chair time-out (Taylor & Miller, 1997).

We hypothesized that the physical restraint used to manage 2 students' problem behavior in the classroom was contraindicated based on behavioral function. To test this hypothesis, we evaluated the effects of physical restraint as a consequence for problem behavior after results of typical functional analyses were inconclusive.

METHOD

Participants and Setting

Sid, a 13-year-old student who had been diagnosed with Down syndrome, engaged in physical aggression toward teachers and peers and sexual touching of female teachers. Paul, a 13-year-old student who had been diagnosed with mild mental retardation and cerebral palsy, used a wheelchair and engaged in yelling, self-injury, and aggression toward teachers. All sessions were conducted at the participants' school in an unused

Portions of this report were presented at the 26th annual convention of the Association for Behavior Analysis, Washington, D.C., May, 2000.

Correspondence concerning this article should be addressed to Janet Ellis, Department of Behavior Analysis, P.O. Box 310919, Denton, Texas 76203-0919 (E-mail: ellis@scs.cmm.unt.edu).

classroom containing tables, chairs, desks, and materials necessary to conduct the experimental conditions.

Response Measurement and Reliability

Sid's target behaviors were defined as (a) *aggression:* hitting or kicking others, or throwing objects so that they made physical contact with others; and (b) *sexual touching:* touching others' buttocks or genital area. Paul's target behaviors were defined as (a) *yelling:* vocalizations above normal conversational volume; (b) *self-injury:* hitting his face with a closed fist or biting his hand; and (c) *aggression:* hitting, biting, or scratching others, or throwing objects so that they made physical contact with others. Data were collected using 10-s partial-interval recording. Interobserver agreement data were collected for 25% of sessions. Overall agreement averaged 92% for Sid and 80% for Paul.

Procedure

Functional analysis. Participants were exposed to four functional analysis conditions alternated in a multielement design, as described by Iwata, Dorsey, Slifer, Bauman, and Richman (1982/1994). Three to five daily 15-min sessions were conducted with each participant, 3 days per week. A different therapist conducted each condition. During the no-interaction condition, the student was in the room with a therapist who did not interact with him. During the attention condition, the therapist ignored the student but made statements describing the behavior following each occurrence of a target behavior (e.g., "You hit yourself," "You are yelling"). During play sessions, the therapist interacted continuously with the participant but withdrew attention for 30 s contingent on any target behavior. During the demand condition, the therapist delivered requests (e.g., "Write your name," "Count the dots") continuously for both subjects. With Sid, the therapist moved away and discontinued requests for 30 s contingent on occurrences of the target behavior. Paul was wheeled into a time-out area for 30 s following each target behavior.

Evaluation of physical restraint. Results of informal, naturalistic observations of each participant in the classroom prior to the functional analysis indicated that teachers used physical restraint several times each day following inappropriate behavior. Based on these observations, the effects of physical restraint (i.e., basket-hold time-out) on problem behavior were evaluated. The specific antecedents and consequences were analogous to those observed in the classroom. For Sid, the physical restraint condition was identical to the attention condition except that the therapist placed him face down on the floor and held his arms behind his back for 10 s contingent on target behavior. For Paul, procedures were identical to the demand condition except that following occurrences of the target behavior, the therapist folded his arms across his chest and held his wrists under his armpits for 10 s while he remained seated in his wheelchair. Physical restraint and play conditions were alternated in a multielement design.

RESULTS AND DISCUSSION

Results of Sid's initial functional analysis are shown in Figure 1. Problem behavior initially occurred in the attention and play conditions but decreased to zero across sessions. High levels of problem behavior occurred in the physical restraint condition. These findings suggested that physical restraint either maintained or evoked Sid's problem behavior.

For Paul, problem behavior occurred in both the attention and demand conditions but increased across sessions only in the de-

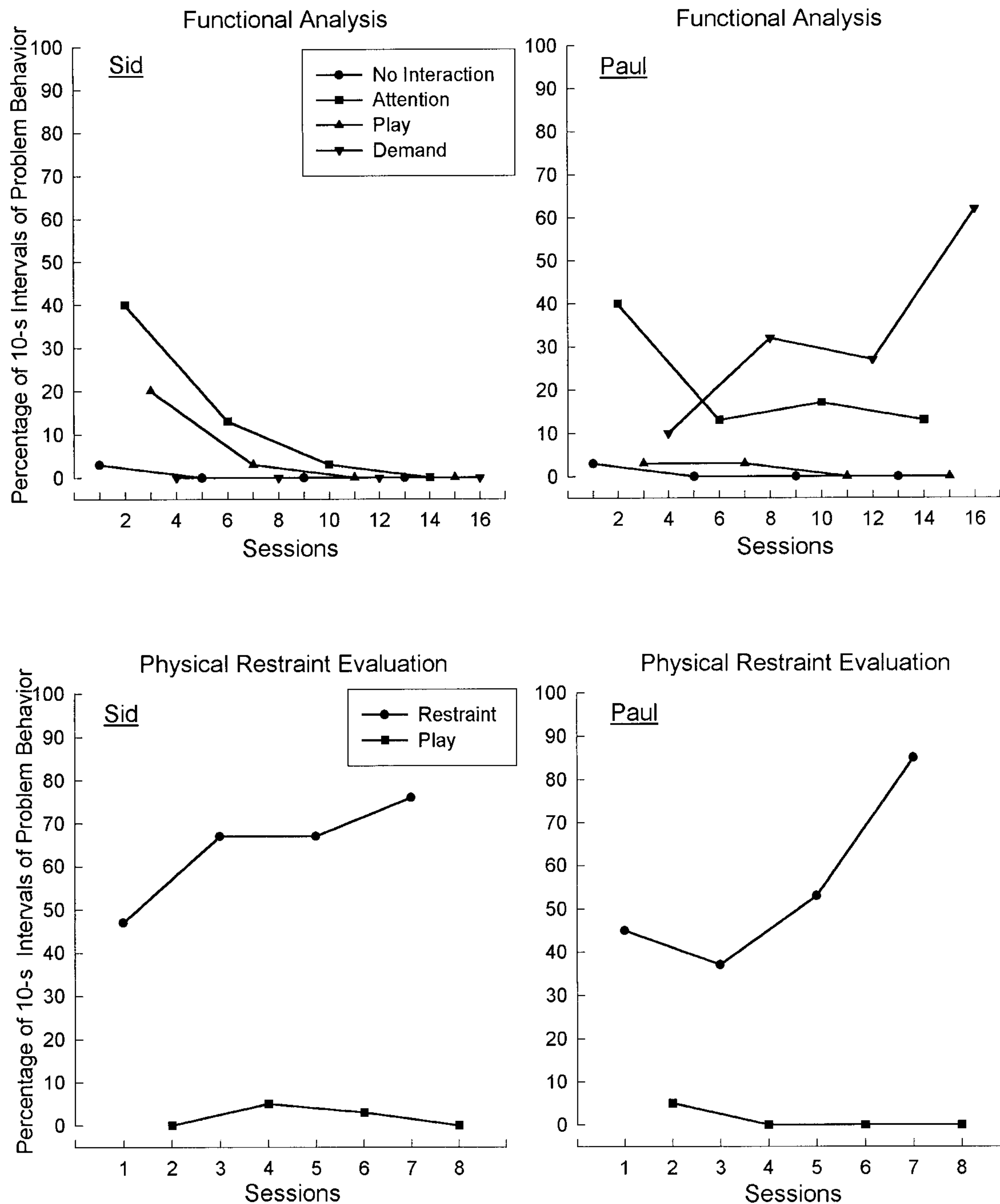

Figure 1. Problem behavior during the functional analysis and physical restraint evaluation for Sid and Paul.

mand conditions (Figure 1). These results suggested that escape from demands and possibly access to attention maintained Paul's problem behavior. High levels of problem behavior continued to occur in the demand condition when physical restraint was used. These results further suggested that Paul's problem behavior was main-

tained by escape from demands and that the use of physical restraint following occurrences of problem behavior was contraindicated because demands were briefly removed while restraint was applied. Based on these outcomes, physical restraint was discontinued in the classroom, and effective interventions involving differential reinforcement and extinction were identified for both students.

These findings highlight the importance of identifying and evaluating idiosyncratic events that may be functionally related to problem behavior, especially when initial assessment outcomes are unclear (e.g., Piazza et al., 1999). For Sid, physical interaction rather than verbal attention was a positive reinforcer for problem behavior. Results for both participants also showed the detrimental effects of using physical restraint when this common classroom intervention is applied without regard for the function of problem behavior.

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Piazza, C. C., Bowman, L. G., Contrucci, S. A., Delia, M. D., Adelinis, J. D., & Goh, H. L. (1999). An evaluation of the properties of attention as reinforcement for destructive and appropriate behavior. *Journal of Applied Behavior Analysis, 32,* 437–449.

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Action Editor, Dorothea C. Lerman

International Journal of
Mental Health Nursing

International Journal of Mental Health Nursing (2010) 19, 416–427 doi: 10.1111/j.1447-0349.2010.00694.x

Feature Article

Perspectives on the experience of being physically restrained: An integrative review of the qualitative literature

Tania D. Strout
Maine Medical Center, Department of Emergency Medicine, Portland, Maine, USA

ABSTRACT: *Publications providing information on the safe use of physical restraints, guidelines for restraint use, and journal articles on the care of mental health patients are frequently devoid of information regarding patients' perspectives on physical restraint. As physical restraint is a common procedure in many settings, the purpose of this review is to examine and summarize the qualitative literature on patients' perspectives on being physically restrained, from 1966 through to 2009. A formal integrative review of existing qualitative literature on patients' perspectives of physical restraint was conducted. Studies were critiqued, evaluated for their strength, and analysed for key themes and meanings. Twelve studies were ultimately identified and included in the review. Four themes emerged from the review, including negative psychological impact, retraumatization, perceptions of unethical practices, and the broken spirit. While little qualitative research on patients' perceptions of physical restraint exists, findings within the current literature reveal serious implications for patients and nurses alike. Additional research into physical restraint implications for the patient–nurse dyad is needed, and nurses should approach the use of physical restraint with caution and awareness of their potential psychological impact.*

KEY WORDS: *nursing, patient experience, physical restraint, qualitative research, restraint.*

INTRODUCTION

While there is very little evidence supporting the efficacy and safety of physical restraint, the practice has a long history of use and is traditionally considered by clinicians to be therapeutic (Evans *et al*. 2003; Gerolamo 2006; Irving 2002; Johnson 1998; Sailas & Fenton 2000). In fact, although there is a paucity of literature reporting restraint-associated benefits, there is an abundance of literature reporting complications of restraint use (Gerolamo 2006; Irving 2002; Nelstrop *et al*. 2006; Sailas & Fenton 2000; Stewart *et al*. 2009; Tumeinski 2005; Zun 2003). Restraint use has been found to give rise to increased length of hospitalization (Frengley & Mion 1986; Mion *et al*. 1989; Robbins *et al*. 1987), higher mortality (Frengley & Mion 1986; Mion *et al*. 1989; Mohr *et al*. 2003; Molasitotis 1995; Paterson *et al*. 2003; Robbins *et al*. 1987; Zun 2003), pressure sores (Lofgren *et al*. 1989; Stiebeling *et al*. 1990), higher rates of nosocomial infections (Lofgren *et al*. 1989; Mion *et al*. 1989; Molasitotis 1995; Robbins *et al*. 1987), higher rates of falls (Mion *et al*. 1989; Tinetti *et al*. 1992), and aggression–coercion cycles for both patients and staff (Goren *et al*. 1993; Paterson & Duxbury 2007).

Physical restraint also has important implications for nurses and other staff. Stubbs *et al*. (2008a,b, 2009) have reported extensively on physical injuries to nursing staff sustained during physical restraint interventions. Nurses have been noted to suffer psychological consequences

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related to restraint use, including distress, anxiety, anger, and retraumatization for victims of prior trauma (Bigwood & Crowe 2008; Bonner *et al*. 2002; Fish & Culshaw 2005; Sequeira & Halstead 2002). Bigwood and Crowe (2008) have reported on the conflict that nurses who utilize restraints might feel when the needs for maintaining safety and control collide with professional values emphasizing the therapeutic nurse–patient inter-relationship (Peplau 1952).

Publications providing information on the safe use of physical restraints, guidelines for restraint use, and educational articles on the care of mental health patients are virtually devoid of information regarding patients' perspectives on physical restraint. As nurses, we have a moral imperative to promote well-being for our patients through excellent nursing practice. Excellence in practice requires that we have an understanding of the meaning that our practices have for patients, and to that end, an understanding of the meaning of physical restraint is essential to best caring for those experiencing this intervention. While definitions of physical restraint vary widely, generally, 'restraint' refers to physically restricting movement (Mohr *et al*. 2003), and this broad definition of physical restraint will be used for the purpose of this paper. The purpose of this integrative review is to examine and summarize the currently-available qualitative research findings regarding patients' perspectives on being physically restrained. This information is intended for consideration by practicing nurses and other clinicians who encounter physical restraint situations in their practice settings.

METHODS

An integrative review of the literature was conducted utilizing the general framework for research synthesis described by Harris Cooper (2010). Cooper identifies seven stages in his research synthesis methodology, including: (i) problem formation; (ii) literature search; (iii) gathering data from studies; (iv) evaluating study quality; (v) data analysis and integration; (vi) data interpretation; and (vii) presentation of the findings. Cooper's stages of research synthesis were used as a framework for systematically evaluating existing reports of research in order to identify patients' perspectives on being physically restrained. The study methodology is diagrammed in Figure 1.

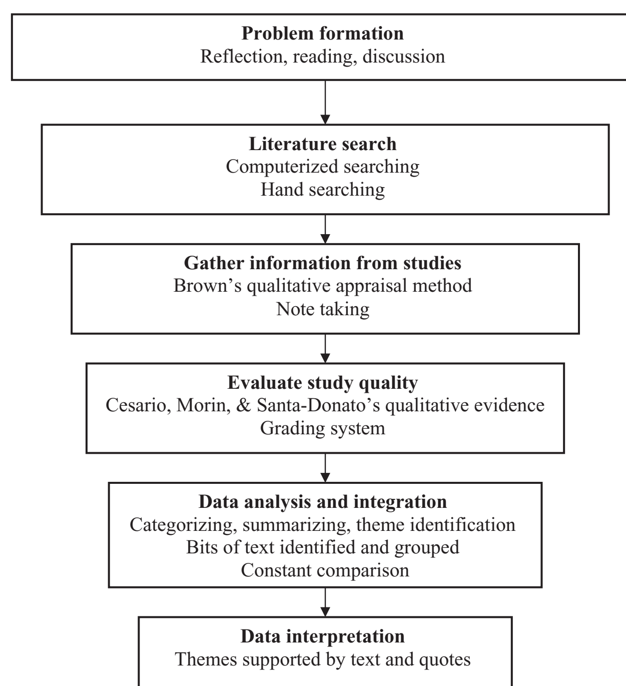

FIG. 1: *Study methodology.*

Data collection

Sampling method

Published reports of research were identified through systematic computerized searches of applicable databases. The CINAHL (Cumulative Index of Nursing and Allied Health Literature), PubMed (United States National Institutes of Health), Medline (Medical Literature Analysis and Retrieval System Online, National Library of Medicine), and PsychINFO (American Psychological Association) databases were reviewed. The keywords used separately and in combination in the computerized searches included 'physical intervention', 'physical restraint', 'restraint', 'experience of being restrained', 'patient experience', and 'patient perceptions'. Reference lists from articles retrieved in the computerized search were individually reviewed and scrutinized to detect any additional articles that were not identified in the computerized literature search. These initial searches yielded approximately 3000 articles for consideration. The titles of these papers were reviewed for relevance; those covering unrelated topics (e.g. Reflecting on a program of participatory ergonomics interventions: A multiple case study (Cole *et al*. 2009)) were eliminated. In summary, 128 potentially relevant journal articles were identified, and their abstracts were reviewed for possible study inclusion.

Inclusion criteria

Only peer-reviewed reports of research appearing in English-language journals that were published between 1966 and 2009 were included in the integrative review.

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This range of dates was chosen in an attempt to cast a very wide net and identify all evidence addressing the topic under study. In order to focus on the patients' reported experience of physical restraint, only qualitative articles or articles with a qualitative component addressing the phenomenon of interest were included. Papers were not excluded based upon study setting (e.g. acute care versus outpatient setting) or based upon the medical diagnoses of the study participants (e.g. mental health versus medical–surgical populations).

Exclusion criteria

Journal articles or papers that did not describe original research were excluded from the integrative review and accounted for seven of the 128 papers considered. Papers that did not specifically address patients' perceptions or experiences of being restrained were excluded; this accounted for the vast majority of excluded papers: 108 in all. One full dissertation was excluded because a research article describing the same project was included in the review. No abstracts or unpublished manuscripts were included. Using these criteria, 12 articles were identified for inclusion in the integrative review. During the literature review process, it was noted that although there were many papers touching on the topic of physical restraint peripherally, for example, on nurses' decision making of physical restraint and the ethics of physical restraint use (Mohr 2009; Moylan 2009), the number of papers germane to the precise topic of patients' experiences of being physically restrained was very small, resulting in the small number of manuscripts included in this review. Table 1 provides a summary of the included studies, and Figure 2 provides a schematic of the manuscript selection process.

Data evaluation

Appraising the evidence

Each article selected for inclusion in the integrative review was appraised using the systematic methodology described by Brown (1999). Specifically, she provides appraisal questions to guide a reader's assessment that are particular to qualitative research reports. Focus areas covered using this technique include development of a synopsis, credibility profile, clinical significance profile, and applicability profile. The process was used to guide reflection on and synthesis of the manuscripts. Studies were also evaluated for methodological rigor, theoretical rigor, and the relevance of the data the authors reported collecting. Methodological rigor was evaluated by comparing the described methods with generally accepted standards for individual qualitative methods. Theoretical rigor was appraised by comparing described methods with stated philosophic underpinnings for congruence. Data relevance was checked by comparing collected data with the described method and study question or purpose.

Grading the evidence

A variety of evidence hierarchies or grading systems are available to rank evidence sources according to validity and strength. Here, Cesario *et al.*'s (2002) evidence grading system for appraising qualitative studies has been used as a guide for evaluating studies related to patients' experiences of being physically restrained; this is described below. While some might find evidence hierarchies incongruent with the underpinnings central to qualitative methodologies, it should be noted that multiple authors recognize both quantitative and qualitative research methods as capable of producing valid sources of evidence (Cesario *et al.* 2002; Evans 2003; Polit & Beck 2008).

Cesario *et al.* (2002) describe five categories for evaluating qualitative research: descriptive vividness, methodological congruence (including rigor in documentation, procedural rigor, ethical rigor, and confirmability), analytical preciseness, theoretical connectedness, and heuristic relevance (including intuitive recognition, relationship to existing body of knowledge, and applicability). With this system, studies are scored using a four-point quality rating scale in each of the categories. A total quality of evidence rating score is calculated by summing categorical total scores, yielding evidence quality ratings ranging from QI (strongest evidence) to QIII (least strong evidence) (Cesario *et al.* 2002).

RESULTS

Characteristics of the studies included

Of the 12 studies included, three were conducted in the USA (Johnson 1998; Minnick *et al.* 2001; Strumpf & Evans 1988), one utilized a Canadian setting (Gallop *et al.* 1999), five were from settings within the UK (Bonner *et al.* 2002; Fish & Culshaw 2005; Jones & Kroese 2006; Sequeira & Halstead 2001; 2002), two were from China (Chien *et al.* 2005; Wong & Chien 2005), and one was conducted in Norway (Wynn 2004). The types of clinical units the studies were conducted on varied as well. Seven studies utilized inpatient psychiatric settings (Bonner *et al.* 2002; Chien *et al.* 2005; Gallop *et al.* 1999; Johnson 1998; Sequeira & Halstead 2001; 2002; Wynn 2004). Inpatient medical units were study sites in two cases

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TABLE 1: *Summary of studies related to patients' perceptions of being physically restrained*

Author/year	Topical focus	Stated method	Sample description	Data analysis procedure	Brief labels for main findings
Strumpf & Evans (1988)	Perceptions of restrained, hospitalized elders and their primary nurses. Subjective impact of restraint and nurses' beliefs about restraint	Qualitative: interviews. Quantitative: Subjective Experience of Being Restrained questionnaire (Pts), Perceptions of Restraint Use questionnaire (RN), Primary Nurse questionnaire (RN)	20 medical patients (elders) in a tertiary hospital and their primary nurses ($n = 18$)	Taped interviews, Questionnaires No discussion of data analysis or interpretation methods	• Anger • Fear • Resistance • Humiliation • Demoralization • Discomfort • Denial • Agreement
Johnson (1998)	Sought to understand the meaning of being restrained for psychiatric patients	Unstructured interviews	Psychiatric patients who had been restrained with leather restraints in an inpatient psychiatric unit ($n = 10$)	Taped interviews were transcribed verbatim and analysed. Analysis was an 8-stage process grounded in Heideggerian phenomenology	• Power • Powerlessness • Separation • Fear/being scared • Dehumanization • Vulnerability
Gallop *et al*. (1999)	Explores the experiences of women with histories of childhood sexual abuse after physical restraint during psychiatric hospitalization	Semistructured interviews	Female psychiatric inpatients who had experienced physical restraint and had a history of sexual abuse during childhood ($n = 10$)	Interviews transcribed in ethnographic software programme, transcripts read and reread by each investigator. Content clustered into general categories. Content from categories reviewed for emerging themes, key themes identified, supported by content, and reviewed by research team	• Findings regarding experience of hospitalization and events leading to physical restraint presented • Experience of restraint: ○ restraint as terrifying ○ being rendered powerless ○ restraint as degrading • No participant felt safe or that restraint was helpful • Restraint led to flashbacks, nightmares, and anxiety related to prior abuse experiences for all participants
Minnick *et al*. (2001)	Patients' perspectives on being restrained: remembering, their perspectives, and distress related to being restrained	Semistructured interviews	Medical or surgical ICU patients from 5 hospitals; elders ($n = 15$)	Audiotaped interviews were transcribed; qualitative analysis of interview transcripts for common themes was conducted. No further description of analytical process	• 40% remembered restraint • Knew what behaviour had caused the restraint, could not stop themselves at the time (e.g. pulling tubes) • Hallucinations/intubation as very disturbing during restraint • Realized no alternative at the time • Felt lives had been in peril and restraint was secondary concern
Sequeira & Halstead (2001)	Examines the use of seclusion, restraint, and rapid tranquilization with patients who have developmental disabilities. Women's experiences of these methods were explored	Qualitative: semistructured interviews. Quantitative: medical records review	Qualitative: female inpatients with developmental disabilities who had experienced seclusion, restraint, or rapid tranquilization ($n = 10$). Quantitative: male and female patients with developmental disability undergoing the aforementioned interventions ($n = 87$)	Qualitative: taped interviews transcribed and subjected to thematic content analysis. Guided by grounded theory procedures. Quantitative: nursing staff completed records following seclusion, restraint and tranquilization intervention. No information on methods of data abstraction provided	• Qualitative methods resulted in four themes crossing the three interventions: ○ physical pain or discomfort ○ anxiety and mental distress ○ punishment and control ○ personal anger, desire to express further aggression • Quantitative results: ○ women involved in a disproportionately larger number of incidents ○ women had a significantly higher likelihood of being sedated following a restraint or seclusion incident ○ men were more likely to experience seclusion
Bonner *et al*. (2002)	Solicit factors that patients and staff found helpful and unhelpful during and after restraint incidents	Semistructured interviews	Patients and staff involved in 6 restraint incidents that occurred in an inpatient psychiatric unit	Taped interviews were transcribed verbatim. Transcripts analyzed independently by the 3 researchers. During first-level coding, initial codes were organized into themes. Incidents were examined both as individual incidents, and then as whole transcripts	Antecedents • Ward atmosphere • Failed communication In midst of conflict • Fear and embarrassment • The last resort • Planning, containment, & support The aftermath • Distress in the aftermath • Resolution (pts) the need for understanding and support • Resolution (nurses) debriefing Other Issues – Pts • Fear of restraint • Restraint and retraumatization • Agency staff Other Issues – Staff • Ethical issues • Retraumatization

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TABLE 1: *Continued*

Author/year	Topical focus	Stated method	Sample description	Data analysis procedure	Brief labels for main findings
Sequeira & Halstead (2002)	Examines experiences of physical restraint for mental health inpatients	Semistructured interviews	Inpatients from a secure mental health service facility ($n = 14$).	Grounded theory methodology used. Interview transcripts studied using thematic content analysis. Low level categories identified, compared, and grouped into more abstract themes. Both authors reviewed transcripts and themes, restudying and discussing until consensus was achieved	• Negative psychological experiences reported • Anger • Anxiety • Restraint as punishment • Restraint as inciting further violence and aggression • Retraumatization for victims of prior sexual abuse • A way to release feelings • A sense of containment
Wynn (2004)	Explores how physical restraint is experienced from the perspective of psychiatric inpatients. Focuses on participant perceptions of why restraint is used, whether it could have been avoided, and its outcomes	Semistructured interviews	Psychiatric inpatients who had recently experienced restraint ($n = 12$)	Following informal discussion with participants to identify important topics, qualitative interviews were conducted Taped interviews were transcribed. Grounded theory methods used – data were collected and analyzed simultaneously until saturation. Data condensed, categorized into themes, categories examined using constant comparative method	• Participants readily identified reasons they had been restrained: ○ treatment refusal ○ refusal to follow staff directions ○ loss of control – self-harm or aggression towards others • Opinions on whether restraint could have been avoided ○ more positive attention/open communication could have avoided restraint ○ approach emphasizing security in a non-threatening manner could have avoided restraint ○ perceived as defending themselves ○ some with psychosis/hallucinations understood the need for restraint • Experiences ○ most actively resisted/fought ○ defending self ○ resistance futile ○ frightened, anxious, angry, scared, aggressive ○ some reported calming following restraint ○ retraumatization for victims of prior abuse ○ delusions/hallucinations during restraint ○ physical injuries ○ felt restrained too long • Outcomes/consequences ○ anger ○ none labelled a positive experience ○ felt it was a demonstration of power, distrusting of staff ○ violated their integrity ○ felt unfairly treated
Fish and Culshaw (2005)	Explores staff and client accounts of aggressive incidents and consequences of physical restraint.	Unstructured interviews	Staff and clients from a secure learning disability centre (staff: $n = 16$, clients: $n = 9$)	Participatory research framework used. Transcribed documents were studied using Hycner's guidelines for phenomenological analysis. Each unit of interview text was read and simplified or categorized; categories grouped together and treated as interview themes. Researchers met to compare themes; common themes are presented	• Clients ○ ward atmosphere as reason for aggressive behaviour ○ restraint made them more frustrated ○ brought back memories of prior frightening experiences • Staff ○ incidents as upsetting and traumatic ○ feelings of guilt and self-reproach ○ an intervention of last resort • Time-outs and post-incident debriefing valued by clients and staff
Wong & Chien (2005)	Explores young patients' perspectives and experiences around the use of physical restraint during acute care hospitalization	Semistructured interviews	Six patients aged 20–40 years who had their first experience of physical restraint during medical hospitalization	Taped interviews were transcribed by the two researchers working independently. Transcriptions were compared for accuracy. Content analysis used to codify and categorize data by the two researchers. No further description of analytical process	• Perceived rationale for restraint to be maintenance of safety and treatment regime or prevention of disturbances to routine, staff, or other patients • Experienced more negative than positive feelings including: discomfort, fear, anger, humiliation, helplessness, and self-blame • Some experienced feelings of safety, being helped, and concern from nurses while restrained

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TABLE 1: *Continued*

Author/year	Topical focus	Stated method	Sample description	Data analysis procedure	Brief labels for main findings
Chien *et al.* (2005)	Explores experiences and feelings of psychiatric inpatients concerning their first encounters with physical restraint. Focus on whether restraint had effects other than protection	Qualitative: semistructured interviews. Quantitative: medical record reviews	Psychiatric inpatients with violent behaviours who had their first physical restraint experiences during hospitalization ($n = 30$)	Taped interviews were transcribed by a researcher and research assistant. Transcripts reviewed by qualitative expert who suggested amendments. Researchers identified themes, checked coding reliability. Content analysis through matching and condensing, described as a series to six stages of analysis. Chart review methods were not discussed	• Participants indicated positive and negative impacts of restraint: • Positive themes: ○ safety and trust ○ caring and concern ○ explanation and frequent interaction ○ being respected • Negative themes: ○ lack of concern and empathy ○ failure to provide information ○ powerlessness and uncertainty • Some patients also reported feeling anxious and fearful while restrained
Jones & Kroese (2006)	Views of clients (learning disabled) who are frequently restrained regarding their restraint experiences	Semistructured interviews	10 clients from secure residential facilities who are learning disabled and are frequently restrained	Semistructured interviews; analytical plan was not discussed	• Absence of emotional content notable • Restraint as a functional, non-communicative process • Need for increased communication • Staff as not enjoying restraint • Improper or abusive practices • Need for staff training around restraint

ICU, intensive care unit; Pts, patients; RN, registered nurse.

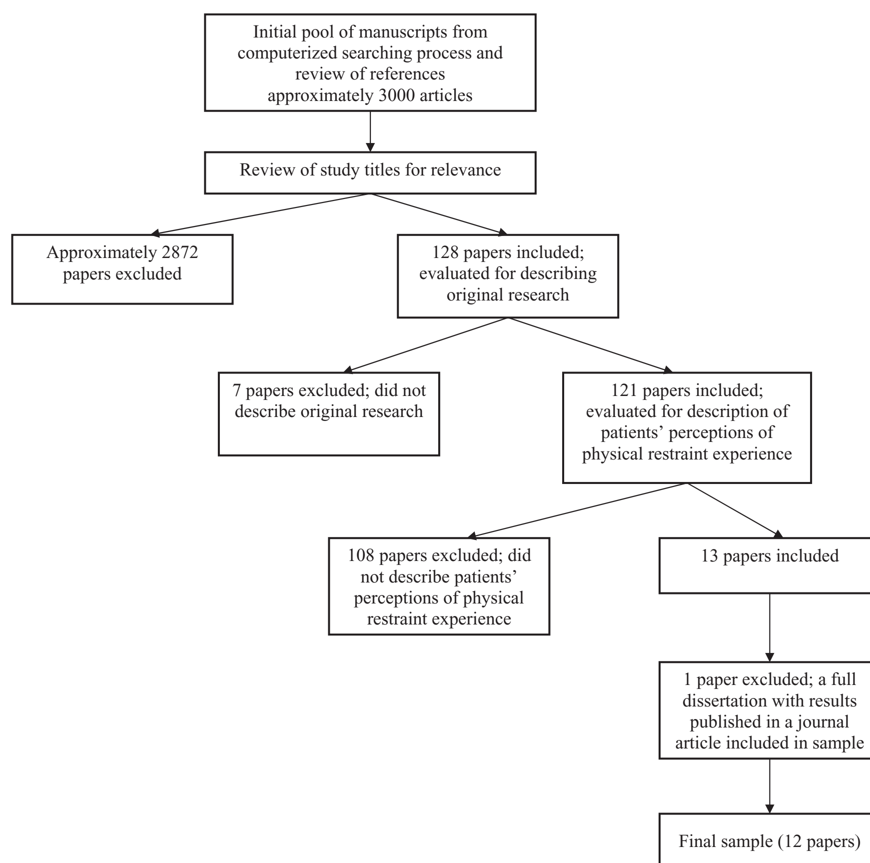

FIG. 2: *Manuscript selection process.*

(Strumpf & Evans 1988; Wong & Chien 2005), and a medical–surgical intensive care unit provided the clinical setting for one study (Minnick *et al*. 2001). Two papers described conduct at inpatient residential facilities for people with developmental or intellectual disabilities (Fish & Culshaw 2005; Jones & Kroese 2006).

The ages of the study participants were generally reported as ranges, with one focusing on specifically older

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adults (Strumpf & Evans 1988), and one including mid adult to older adult participants (Minnick *et al.* 2001). Two studies included participants ranging from teenagers to mid adults (Sequeira & Halstead 2001; Sequeira & Halstead, 2002). Middle-aged adults participated in seven studies (Bonner *et al.* 2002; Chien *et al.* 2005; Gallop *et al.* 1999; Johnson 1998; Jones & Kroese 2006; Wong & Chien 2005; Wynn 2004), while one study did not provide information regarding age (Fish & Culshaw 2005).

Most commonly, participants were described as undergoing physical restraint with extremity or vest restraints (Chien *et al.* 2005; Minnick *et al.* 2001; Strumpf & Evans 1988; Wong & Chien 2005), while one study focused specifically on leather extremity restraints (Johnson 1998). Two studies described physical holding without a restraining device (Fish & Culshaw 2005; Sequeira & Halstead 2001), two described restraint as being 'manual' (Bonner *et al.* 2002; Jones & Kroese 2006), and three reported the mode of restraint only as 'physical' (Gallop *et al.* 1999; Sequeira & Halstead 2002; Wynn 2004).

Strength of the evidence

The papers included in this review are representative of QI and QII evidence, using Cesario *et al.*'s (2002) hierarchy. Nine manuscripts are reports of research conducted utilizing qualitative methods (Bonner *et al.* 2002; Fish & Culshaw 2005; Gallop *et al.* 1999; Johnson 1998; Jones & Kroese 2006; Minnick *et al.* 2001; Sequeira & Halstead 2002; Wong & Chien 2005; Wynn 2004). Three manuscripts report the use of a mixed-methods approach, where both qualitative interviews and quantitative surveys or records reviews were conducted (Chien *et al.* 2005; Sequeira & Halstead 2001; Strumpf & Evans 1988). Five articles were evaluated as providing QI evidence (Bonner *et al.* 2002; Gallop *et al.* 1999; Johnson 1998; Sequeira & Halstead 2001; Wynn 2004). The remaining seven papers provided QII or middle-level quality evidence. In general, the QII articles were judged as having lesser methodological congruence, confirmability, analytical preciseness, and theoretical connectedness than the QI papers.

Critique of methods

In general, several of the papers reviewed provided little to no description of the methods of analysis used to arrive at the author's conclusions (Jones & Kroese 2006; Minnick *et al.* 2001; Strumpf & Evans 1988; Wong & Chien 2005). Despite this limitation, all relevant studies were included in this review due to the small number of papers available on the topic. Eleven of the papers described what can be evaluated as qualitative descriptive methods, although the authors did not overtly state that qualitative description was their research method. Three of these papers described the use of methods guided by the methods of grounded theory; however, none of these three papers reported on a theory of the phenomenon of interest (Sequeira & Halstead 2001; 2002; Wynn 2004). Rather, the authors used some methods of data analysis consistent with grounded theory methodology (Creswell 2007; Strauss & Corbin 1998). One group wrote of having a 'more participatory framework', as participants were empowered to lead interview conversations (Fish & Culshaw 2005, p. 97), but again, the study did not meet methodological standards for participatory action research (Whyte 1991).

Only one paper clearly stated the philosophical underpinnings that grounded the work, Heideggerian phenomenology, and described how these underpinnings guided the methods and modes of data collection and analysis (Johnson 1998). Consistent with the purpose of interpretive phenomenology, this paper successfully provided insight into the 'meaning' of the experience of being restrained; many of the other papers all provided more general descriptions of the phenomenon. In addition, Johnson's (1998) paper offers the reader thick description and many rich quotes from the study participants. While the other papers do contain some participant quotes, they tend to be few, brief, and not as rich and full of meaning as those provided by Johnson.

During review, it was also noted that some authors made an attempt at quantifying qualitative data, for example, by writing how many reasons for restraint the patients and nurses identified (Strumpf & Evans 1988) or by reporting the number of participants experiencing powerlessness during physical restraint (Chien *et al.* 2005). In the absence of more interpretation of the participants' experiences of being restrained, this type of quantification is of limited utility and can be offered as a general weakness of the body of literature as a whole. In addition, most authors did not verify their findings with the participants, with the exception of the two papers that seemed quite focused on uncovering the meaning of the restraint experience (Bonner *et al.* 2002; Johnson 1998). Participant verification, the process of checking themes and findings with study participants for fittingness and appropriateness, might have increased the sense that the conclusions of the other authors were trustworthy and valid. Finally, one set of authors reported conducting their participant interviews with patients who were still physically restrained during the interview (Strumpf & Evans 1988). They provided no discussion on the rationale for, decision making around, or ethical implications of this decision; however, as the study was conducted

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more than 20 years ago, ethical standards regarding such issues might have evolved. It should be noted that through this work, Strumpf and Evans did provide the foundation for the further development of nursing knowledge in this area.

The purpose of this integrative review was to examine and summarize the qualitative research regarding patients' perspectives on being physically restrained. Strategies used to complete this task were categorizing, summarizing, and identifying themes that evolved through a thorough reading and rereading of this literature. Copious notes were taken during the readings and were also read and reread during the process of analysis. Written critiques using Brown's (1999) methods were completed and were also reviewed during analysis. Important bits of text from the manuscripts and notes were highlighted and organized into groups of text with similar content and meaning. As the manuscripts and notes were reread, additional pieces of text were added to the categories, and the categories were continually evaluated for underlying similarities during the process of constant comparison (Strauss & Corbin 1998). Ultimately, four themes were identified though this review, including negative psychological impact, retraumatization, perceptions of unethical practices, and the broken spirit.

Negative psychological impact

One author reported statements by eight study participants that physical restraints reduced the likelihood of physical injury (Jones & Kroese 2006). Two study groups reported positive feelings associated with restraints that were identified by study participants (Chien *et al*. 2005; Wong & Chien 2005). Medical inpatients participating in interviews regarding their experiences reported feelings of safety, being helped, and concern from nurses while they were restrained; however, study participants reported more negative feelings overall (Wong & Chien 2005). Chien *et al*. (2005) conducted a mixed-methods study investigating psychiatric inpatients' experiences of physical restraint. Some participants in their study reported feelings of safety and trust in their nurses, caring and concern from nurses while they were restrained, and feelings of being respected. Again, these participants also reported negative experiences more than positive experiences and feelings overall. As discussed below, negative psychological experiences were much more the norm in this body of literature.

While participant reports of positive restraint experiences were rare, all the studies reviewed included a discussion of the negative psychological impact the experience of being physically restrained had on the participants. Common themes included anger, fear, humiliation, demoralization, dehumanization, degradation, powerlessness, distress, embarrassment, and feeling that their integrity as a person had been violated (Bonner *et al*. 2002; Chien *et al*. 2005; Gallop *et al*. 1999; Johnson 1998; Jones & Kroese 2006; Sequeira & Halstead 2001; 2002; Strumpf & Evans 1988; Wong & Chien 2005; Wynn 2004). On feeling humiliated, one participant, a medical patient, described feeling as if he or she were nailed to a cross (Strumpf & Evans 1988). On feeling dehumanized, a psychiatric patient restrained with leather restraints reported:

> I felt very uncomfortable. Like I was an animal being chained up. Only difference was, wasn't chains around my neck . . . I felt dirty . . . Not being funny, but my mind went back to stories my grandma told me about slavery days. I felt like I was a slave. I was I chained up, I couldn't do anything. I was under somebody else's command. (Johnson 1998, p. 201)

The negative psychological impact that being physically restrained can have is a very important theme because clinicians generally consider the use of physical restraint to be a therapeutic intervention. In fact, the use of physical restraint is typically only permitted as a therapy that is part of a larger behavioural therapy programme, but the negative psychological consequences reported by patients call into question the therapeutic value of the restraint intervention.

Retraumatization

Several authors reported retraumatization as a consequence of physical restraint. Many participants reported that the experience of being restrained brought back memories of previous violent attacks against them, including experiences of being raped and having been abused as a child (Bonner *et al*. 2002; Fish & Culshaw 2005; Gallop *et al*. 1999; Sequeira & Halstead 2002; Wynn 2004). One participant with a history of childhood sexual abuse stated: 'It brought it all back. I felt – I actually physically felt like I was being raped that whole night long' (Gallop *et al*. 1999, p. 411). Another reported: 'They had me spread-eagle again, and that's terrible. If only when they restrain you your legs could be together. It's like you're ready to be raped. It really is a violent vulnerability' (Gallop *et al*. 1999, p. 411). An elderly hospitalized participant reported feeling like a prisoner of war (Strumpf & Evans 1988). Other psychiatric unit participants reported feeling 'like a victim again', 'victimized', and 'traumatized' (Johnson 1998). The existence of feelings of retraumatization as a consequence of physical restraint again calls

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into question any therapeutic value obtained through the use of this intervention, and underscores the potential harm that physical restraint utilization produces.

Perceptions of unethical practices

Participants in six of the 12 studies included descriptions of incidents that they felt were punitive, abusive, or unethical practices undertaken by clinicians during their restraint experiences (Bonner *et al*. 2002; Johnson 1998; Jones & Kroese 2006; Sequeira & Halstead 2001; 2002; Wynn 2004). One participant reported that staff members taunted her while she was restrained: 'She stated, "They laugh about it. 'We're going to the pub' they tell you" ' and, 'They threw a sharp medicine bottle in and told me to get on with it. To cut myself. They know I cut myself' (Jones & Kroese 2006, p. 52). Another participant in the same study stated: 'Staff member said he would break my legs. Punched me in the face, head, and stomach, bruised my legs and armpits' (Jones & Kroese 2006, p. 53). The frequency with which study participants have reported this type of episode makes them hard to ignore as an angry participant's attempt at retribution. It clarifies the need for extensive training for nurses working in settings where physical restraint is common, and begs the need for restraint to be an intervention of last resort that is never used vindictively or as a form of punishment.

Broken spirit

In each article reviewed, there is indication that participants felt helpless, hopeless, and as if their spirits had been broken at some point during their restraint experience. The participants described coming to some place of acceptance, knowing that there was nothing they could do to get out of the restraints. A hospitalized intensive care patient described giving up and becoming mouse-like during their experience (Strumpf & Evans 1988). Another medically-hospitalized patient described finally accepting the restraints, as 'nothing else could be done' (Minnick *et al*. 2001, p. 170). A psychiatric inpatient participant in one study described feeling 'like a bug, like an ant' (Gallop *et al*. 1999, p. 411). Jones & Kroese (2006) describe an absence of emotional content from their participants, indicating a habituation and socialization to the frequent use of physical restraints in their population of learning-disabled participants. One hospitalized psychiatric patient described his feelings of helplessness:

> They had to feed me from the spoon. Feed *me* . . . They had to feed me like I'm helpless. Which I was. In restraints, you are helpless. Arms tied down. Ankles tied down . . . Like I say, make you feel like you're a helpless person (Johnson 1998, p. 201).

These participants and others describe reaching a place where their physical and emotional resources are used up after fighting their restraints for so long. This is a place of exhaustion, a hopeless place where patients' spirits are broken. Rather than promoting humanization, the physical restraint intervention dehumanizes and creates spiritual distress in these patients (Willis *et al*. 2008).

DISCUSSION

Limitations

This review is limited by the relatively small number of relevant manuscripts identified for review and by the somewhat limited quality of some of the studies reviewed. Only five papers were appraised as being of the highest quality (Cesario *et al*. 2002), and only one study was clearly guided by and consistent with an identified research tradition (Bonner *et al*. 2002; Gallop *et al*. 1999; Johnson 1998; Sequeira & Halstead 2001; Wynn 2004). These issues could limit the utility and transferability of the synthesized findings.

In addition, these findings might be limited by the inclusion of only qualitative studies. This was done intentionally, to focus solely on patients' perceptions of their restraint experiences, as described in their own words. While quantitative work has generated many important findings regarding the effects of physical restraint (Gerolamo 2006; Irving 2002; Nelstrop *et al*. 2006; Sailas & Fenton 2000; Stewart *et al*. 2009; Tumeinski 2005; Zun 2003), these results do not shed light on patients' perceptions of the experience of being physically restrained. In addition, the inclusion of quantitative evidence here would have weakened the current study by introducing an important methodological incongruence that would not be in keeping with the qualitative philosophical underpinnings essential to this work. Creswell (2007) wrote of methodological congruence, 'that the purposes, questions, and methods of research are all interconnected and interrelated so that the study appears as a cohesive whole rather than as fragmented, isolated parts' (p. 42); threats to this congruence, as might be introduced by the inclusion of works with different underpinnings, would challenge the trustworthiness of these findings. Additional work integrating the findings of quantitative evidence on physical restraint could be undertaken to increase our understanding of physical restraint effects.

Participants in the studies included in this analysis cover a broad range of ages (teenagers through to the early 90s), clinical settings (inpatient intensive care

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through residential facilities), and underlying conditions (medical–surgical conditions, mental health conditions, learning disabilities). These diverse studies were included due to the small number of published studies covering the specific phenomenon of interest; enough studies in a single setting or with a single population do not exist to have limited the review further. As the use and perceptions of physical restraint can vary from setting to setting and among populations of patient and nurses, the results of the study should be interpreted by individual nurses with these differences in mind. It should also be noted, however, that the included studies did in fact report similar perceptions and experiences across this varied population.

Implications for nursing practice

The findings here suggest that patients often perceive physical restraint as a punitive measure: a consequence of breaking 'rules' (Evans *et al*. 2003; Gerolamo 2006; Irving 2002; Johnson 1998; Sailas & Fenton 2000; Sequeira & Halstead 2001; 2002; Wynn 2004). While we often believe that being restrained will promote safety and help patients who are not in control feel more secure and gain composure, patients experience physical restraint as frightening, coercive, and as creating a feeling of helplessness or even as violating their integrity as a person (Wynn 2004). Many also report feeling more aggressive, violent, or struggling more as a result of being physically restrained (Chien *et al*. 2005; Fish & Culshaw 2005; Sequeira & Halstead 2001; 2002; Wynn 2004). The disconnect between the intent of many clinicians and the perceptions of our patients is striking and can seriously impair the establishment and maintenance of a therapeutic nurse–patient relationship (Wynn 2004). This can be particularly important in the emergency and acute psychiatry settings, where patients frequently do not have well-established relationships with their nurses. While balancing the need for safety, nurses might wish to consider alternatives to physical restraint, including the use of de-escalation techniques, pharmacological interventions, or the implementation of calming interventions aimed at the specific needs of individual patients (e.g. the presence of a support person, nicotine gum, or dimmed lighting). Cowin *et al*. (2003) describe an extensive approach to de-escalating aggression and violence in the mental health setting that has been used as the basis for several interdisciplinary approaches decreasing the use of physical restraint in Australia (Downes *et al*. 2009; Rintoul *et al*. 2009). In addition, Taxis (2002) reported a 94% reduction in the rate of physical restraint and seclusion following the introduction of a comprehensive programme aimed at increasing the use of restraint and seclusion alternatives in a psychiatric hospital. Such programmes provide us with viable alternatives to the use of physical restraint.

In addition, nurses should seriously consider the profound implications of physical restraint use with patients who are survivors of prior childhood or sexual abuse. Carmen and Rieker (1998) provide tools that can be used with patients at risk o requiring physical restraint. These tools assess patients for a history of trauma and post-trauma complications, such as terror and flashbacks, help patients and clinicians to identify helpful strategies to call on during times of crisis (e.g. talking, exercising, listening to music), and elicit patient preferences regarding treatment if restraint is required (e.g. seclusion, type of physical restraint, sex of caregivers during restraint). Using this type of intervention can help patients requiring physical restraint experience fewer negative sequelae.

Directions for future research

Research on the experience of being physically restrained is limited and is of somewhat limited quality. As physical restraint is a high-risk procedure with serious implications for patients and nurses alike, additional research in this area is needed. No research specifically addressing the meaning of the experiences or perceptions of patients physically restrained in the emergency department or acute psychiatry setting was identified. Physical restraint is a common procedure in these settings, and could have additional implications for patients who are generally unfamiliar with the setting and staff caring for them. A phenomenology grounded in the hermeneutic perspective would be of great use in gaining some understanding of the meaning of experiences of physical restraint for these vulnerable patients. Additionally, quantitative studies aimed at evaluating the efficacy of restraint alternatives would provide useful information for clinical practice.

CONCLUSION

Physical restraint is a high-risk procedure that has important implications for the well-being of our patients. Perceptions of patients include feelings of being fearful for their safety, traumatized, powerless, vulnerable, and dehumanized. These generally negative perceptions have important implications for nurses who are attempting to facilitate adaptation and humanization within their patients. The division between beliefs about the therapeutic benefit of physical restraint and the actual perceptions and experiences of our patients points to a serious gap in our understanding about the potentially harmful

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effects of this common intervention. While additional knowledge in this area would be very helpful, nurses should approach the use of physical restraint with caution and awareness of the potential psychological impact of restraint use on their patients.

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INTELLECTUAL AND DEVELOPMENTAL DISABILITIES
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Living Without Restraint: One Parent's Reflections and Recommendations for Supporting At-Risk Individuals With Developmental Disabilities

Wilfred Beaudoin and Adam Moore

Abstract

In the past several years, there has been an important movement to reduce the utilization of restraint for individuals with developmental disabilities. Legislatures, local and national, are taking on the task of shaping the way that our culture supports people who, up until now, have been often treated in a punitive manner rather than truly supportive in a therapeutic way. Schools and systems of care struggle to identify strategies that offer more positive outcomes to all individuals, even those with challenging behaviors. This article represents the thoughts and recommendations of one parent who has lived with the damage done by restraint to his son. The recommendations are intended to speak to administrators, schools, and caregivers. The intent is not to assign blame, but rather to reflect on our experiences and share some strategies that have worked for us. Although much of what is recommended may not be new, the hope is that this article might provide a fresh way to understand some of the factors that contribute to the use of restraint, in addition to providing some suggestions to proactively address those factors.

Key Words: *restraint; debriefing; imminent risk; trauma*

We are a family of three. I am a music teacher in private schools. My wife, Maren, is a retired public school teacher, who began her career as a special needs teacher. When our son, Andre, was born she switched to general education, and ultimately spent many years as a third grade teacher. Throughout her career she remained committed to students with special needs and partnered regularly with special educators to facilitate an inclusive educational experience for all. Andre was born with special needs. When he reached school age, Maren's special needs background informed our interactions with those involved in his education. When Andre's behavior at home and at school became challenging and aggressive I began to play a more active role as a concerned parent and advocate for my son. I became involved with various advocacy groups as I tried to learn about the educational system and ultimately the adult system of care that supports people with disabilities.

Andre is now a 26-year-old nonverbal young man with autism, intellectual disability (ID), a severe anxiety disorder, and some physical limitations due to low muscle tone. His anxiety sometimes manifests in aggression, and sometimes in self-injurious behavior (head banging). When his challenging behavior made it impossible for him to remain at home safely, Andre was admitted to a children's psychiatric hospital at the age of 13. To protect his head from injuries including concussions, Andre was fitted with a martial arts helmet to wear when he engaged in head banging. He hated wearing this helmet, and frequently would remove it when upset.

In 2005, between July 28 and October 3, Andre was put into a prone restraint 30 times in a new placement for him that provided residential and educational services. Twenty-nine of these restraints occurred in school. In each case, the restraint was triggered by aggressive acts from Andre, rooted in his frustration with his program. Our family was not notified of the details of the incidents, nor were we aware of the frequency and duration of the restraints. We had never agreed to such a program of restraints and were alarmed and horrified when we realized the scope of what was occurring to him with regularity. Andre did not have a history of repeated prone restraints before

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the 2005 placement, and he has only been restrained a few times in more than 10 years since leaving that placement. During that 3-month period in 2005, Andre suffered repeated bruising and abrasions. He frequently was observed crying. The situation deteriorated to the point that we chose to remove him from the placement. We were only able to gain insight into the details of Andre's schooldays full of restraint by requesting all records through a lawyer. He was subsequently re-admitted to the psychiatric children's hospital. The psychological impact of the trauma became evident when Andre, within 1 week of his discharge from the residential placement, intentionally smashed his face on a table and needed a trip to the emergency room. From that day forward, Andre insisted on wearing the martial arts helmet every waking minute of every day for the next 6 years. As we think about that awful period in Andre's life as well as other isolated incidents, careful analysis of the facts and circumstances surrounding each incident has convinced us that the decision to restrain him had caused each incident to escalate in intensity, rather than to de-escalate. Although the intent of each restraint was to maintain safety, the restraints had actually caused the environment to become more dangerous. It also became clear to us that much of Andre's frustrations with his situation stemmed from a very prescriptive and rigid program that did not honor his preferences and interests, and instead tried to change what was perceived to be maladaptive behavior. When Andre reacted negatively to this program in the only way that he knew, which was to throw a cup or sweep his lunch off a table, then events escalated quickly into prone restraints.

We began to have more success in reducing the frequency of restraints in subsequent settings when we were able to have meaningful conversations about Andre's program with his clinical team. We have utilized this model in a variety of placements as Andre has transitioned from hospitalization to a group home in the child world, to residential placements in the adult population. Gradually, with work from the entire clinical team, which included our family, he gained enough trust in those around him to feel safe without the helmet. To this day, Andre remains fragile. He can be explosive, and because his language is limited, it is often challenging to identify the root of his frustration when he lashes out or becomes self-abusive.

Recommendations for Professionals From a Parent's Perspective

I will never forget the feelings of utter helplessness as we watched Andre deteriorate over the course of 3 months, not knowing that he was being pinned to the floor with such frequency. In October of 2005, our family made the decision to remove him from the placement where he had been repeatedly placed in prone restraints. In addition to his visible bruises, he had lost trust in all adults outside his immediate family, especially men. In the years since Andre left this placement, we have been devoted to rebuilding his sense of safety as we have worked with his providers to find ways to prevent such restraints from ever happening again. We have come up with some recommendations that may prove useful for professionals who are involved in supporting people with disabilities. My recommendations are consistent with the best practices (e.g., see Office of Special Education Programs [OSEP] Technical Assistance Center on Positive Behavioral Interventions and Supports, 2017; Simonsen, Sugai, Freeman, Kern, & Hampton, 2014) that have been identified in regard to family-school collaboration and positive behavior supports, and may seem like common sense to many. But, the truth is, each recommendation stems from real life experiences with my son. Although it may be tempting to think that these were isolated instances that would never occur again, individuals with disabilities are still being restrained all over the country (i.e., Scheuermann, Ryan, Peterson, & Billingsley, 2013; Westling, Trader, Smith, & Marshall, 2010). Andre remains at risk for physical interventions and has had isolated restraints since his school days. Our family needs to remain vigilant and constantly re-examine factors that can impact his quality of life and in doing so reduce the risk of volatile outbursts. Our hope is that Andre's experience may serve as a mirror of sorts for our system of support, to reflect some of the many facets of care that need attention in order to provide a positive environment for growth for some of our most vulnerable citizens. It should be stressed that our family's view is that the needs, wishes, and hopes of individuals with disabilities should be recognized and honored at all times. Our opinions as family members should not take the place of the opinions of those individuals. The intent of this article is to help to give voice to those who have difficulty advocating for themselves due to com-

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munication deficits or challenging behavior. Ideally, our family's recommendations would be in line with Andre's, and we have attempted to accomplish that to the best of our ability. If even one of these recommendations resonates with a professional, who is moved to examine an internal policy or procedure, then this article will have been a worthwhile endeavor. The recommendations are divided into three categories: (1) Proactive strategies for reducing restraints; (2) Strategies during crisis to de-escalate situations; and (3) Strategies after crisis.

1. Proactive Strategies for Reducing Restraints

Implement positive behavior support from the outset. Preventing the overuse of physical restraints is partially contingent on professionals having alternative strategies to address behavioral challenges. For at least three decades there has been widespread acknowledgement that positive behavior supports which are aligned with function-based interventions provide a more effective means to address challenging behaviors compared to reactive, consequence-oriented approaches such as restraints. Had behavior intervention plans, based on information gathered from a functional behavioral assessment of challenging behaviors, been implemented from the outset to reduce the behaviors that were causing problems for my son and improve socially acceptable alternative behaviors associated with success in school (e.g., see Walker, Chung, & Bonnet, 2017), it is possible that the use of restraints may never have escalated to such an extreme level. The purpose of this article is not to look back and consider all of the potential positive behavioral support strategies that might have been effective had they been implemented. Rather, this article was written to tell the story of how restraints were overused in the case of my son, and to offer advice to those who may either be overusing restraints in their own programs or may find themselves heading down that path. My first piece of advice is for all members of a planning team to make sure positive behavioral supports are in place and implemented correctly. In difficult cases, planning teams may need to consult with a qualified behavioral consultant who has the advanced training and experience necessary to analyze the situation and facilitate the team in identifying and implementing intensive, positive behavioral supports.

Make families part of the support team. Often parents and siblings would like to become active participants in the lives of their family member with a disability, but feel inadequate and unsure of how to contribute to a dialogue about their family member in a productive manner (Tucker & Schwartz, 2013; Tveit, 2009). Professionals can empower families by inviting them into sensitive conversations with clinicians about their loved ones. Really, this is just an extension of the fact that individuals with developmental disabilities need to be recognized as essential members of the support team. Parents and siblings can help to support the ability of people with disabilities to advocate. Families possess a wealth of knowledge about their loved ones that can be of tremendous value to clinicians as they treat the people that they serve. Families should be welcomed to the clinical team without needing to wait for a restraint or significant incident. However, when significant issues do arise, the family can play an important role in achieving a positive outcome. The notion that an incident can be adequately debriefed without input from individuals and their families excludes the voice of the individual from the discussion and ignores the benefit that can result from these sensitive interactions. For Andre, many changes were made in his program in 2005 without meaningful discussion with us, and Andre's dissatisfaction with his circumstances turned to anger and aggression.

In order to fully participate in decisions made by the clinical team, we have learned that we need to be firm in our resolve as family members to obtain as much information as possible about the details of Andre's life, including significant incidents. It is so helpful when families and professionals can come to the table with an open mind and a sincere desire to support the person with a disability. Each party has important contributions to make to conversations about program planning. Neither party should be quick to dismiss the other's contributions. Our family would love to see the removal of all barriers to family engagement in every aspect of the lives of their loved ones.

Provide individualized support. People deserve to be treated as individuals. The disability world is replete with theories and interventions that can apply to individuals with disabilities (Wong et al., 2013). It is dangerous to insist that

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any one intervention should be universally applied to all people supported by a school or agency. Doing so ignores the diversity within the disability community and within mankind. Agencies or educational entities that specialize in one ideology should not end up as the only available placement for an individual.

When Andre was ready to be discharged from the hospital, our family was notified that there was only one available placement for him in the state. Because of his fragile nature, due to his disabilities, our family was determined to keep him nearby, so we accepted that placement. Before long, a therapy that was intended to teach the concept of relaxation to him had the exact opposite result, and instead annoyed him to the point where he became aggressive. To complicate matters even further, the relaxation therapy was also a technique that was used by the agency to de-escalate incidents. The result for Andre was a program that used a therapy that annoyed him as a de-escalation tool for when he was angry. Needless to say it did not work. The required therapies were not therapeutic at all to Andre. They infuriated him. He did not understand them or feel that they had any meaning for him, and the therapies even caused incidents to escalate, resulting in traumatic restraints. Our family feels that the capacity of the system needs to expand to provide quality, individualized care in order to make best practice available to everyone. Individuals and their families should never have just one option or program available to them.

Whenever individuals move to a new school or agency, their individualized education programs (IEPs) or individualized support plans (ISPs) must precede them to the new placements (IDEA, 2004). Although this seems to be obvious, people with disabilities move from school to school or agency to agency, and occasionally the plan to support that individual does not arrive in a timely manner. In Andre's case, the agency that our family had trusted to care for him claimed that they never received the IEP that had been developed for him in the hospital in collaboration with our family. The result was that Andre began in a new setting without the benefit of an individualized support plan that was informed by his history. Instead, the clinical team in the new placement treated him with very prescriptive therapies that Andre did not embrace, as they ignored our input and the knowledge contained in his IEP. The result was disastrous. An individual's IEP and other support plans are documents that must provide the frameworks for establishing new programs after any move.

Create meaningful experiences. People need to have meaning in their lives. Whether in school or adult life, each of us requires instruction or activities that we can understand and that enrich our lives. People with disabilities are no different. The need for meaningful activities does not end at age 21. Activities that are meaningful for an individual have great potential to promote maximum effort and growth. Conversely, activities perceived to be meaningless for someone like Andre will likely result in very little effort or attention on his part. When his perception is that his world is devoid of meaning, the potential for frustration increases dramatically. It is easy to see how this lack of meaning can have dire consequences. Andre is totally dependent on others for personal care, transportation, and a program. When his program lacks meaning, or transportation is a barrier to meaningful activities, frustration understandably begins to build. Over time, that frustration can turn to anger, which can lead to aggression or self-injurious behavior. An example of this might be to note that Andre enjoys being in the community. He loves to be engaged in activities that take him out into the real world. He enjoys interacting with all kinds of people. School activities that required that Andre stay in one place to work on a task often caused him to become anxious. Without the ability to effectively communicate his frustration with his daily routine, Andre occasionally became aggressive or self-injurious. This behavior was interpreted as dangerous and often resulted in the decision to restrain him. Our family is convinced that Andre could have avoided some of these restraints if his program was more meaningful to him. He does best when his program builds on his strengths and interests.

Improve communication skills. In November of 2014, Andre was a passenger in a van across a large bridge when he became frustrated with his ability to accurately communicate his wish to attend a baking class to the staff person who was his driver. Because Andre cannot talk and has a limited communication system, his wishes can sometimes be misinterpreted despite the best of intentions by those who support him. It seemed like that could be what happened in this instance. He became aggressive toward the driver who stopped

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the vehicle on the bridge. Police were alerted that there was a problem on the bridge and soon five squad cars from various jurisdictions were dispatched to the scene. Again, Andre was unable to effectively communicate with the police, who, in spite of the protests of Andre's caregiver, proceeded to restrain him in the van and place him in handcuffs. They then transported him to the local hospital where the emergency room staff administered powerful drugs to sedate him.

This story illustrates the fact that Andre's lack of an effective language impacts every aspect of his life every single day. How different would this story have been if Andre had been able to tell his staff person that he wanted to attend the baking class, or if he had been able to explain to the police that he had a disability and need not be treated as one would treat a criminal? He is one of many nonverbal people who have minimal resources to aid in communication. His lack of an ability to effectively communicate leaves him particularly vulnerable and frequently frustrated with his world. In Andre's case, we believe that his aggressive outbursts and self-abusive behaviors are rooted in his extreme frustration with his inability to adequately communicate with others. As he transitioned into the adult world, our family was confronted with the reality that, for adult individuals with limited ability to communicate like Andre, effective speech therapy ended at age 21. We believe that there is great potential in working to improve speech services for people of all ages who struggle to communicate effectively. With the impressive advances in the iPad and other technology, there are many new opportunities to expand the array of resources available to enhance an individual's capacity to communicate (Boyd, Hart Barnett, & More, 2015). Our family recommends that resources for speech technology and therapy should be available to individuals who need them throughout their lifetime.

Be aware that people with disabilities may have a history of trauma. Past and present trauma is more common among people with developmental disabilities (Conners-Burrow et al., 2013) than many professionals realize. Acknowledging trauma is a necessary first step toward building empathy with those who have been subjected to abuse or neglect directly or indirectly. Relationships are so important for all of us, but imagine how important relationships are for people who are dependent on others for meals, personal care, transportation, money, safety, and countless other things that those of us who do not have a disability take for granted. Let's imagine that an individual develops a trusting relationship with one staff person or several staff people. These are the people that the individual feels are on his side. When a restraint happens, those relationships are severely damaged and sometimes destroyed (National Association of State Mental Health Program Directors [NASMHPD], 2011). Suddenly the staff person who seemed like a trusted friend is pinning the individual to the floor. How is it possible after a restraint to have the same level of trust for those who participated in the restraint? In Andre's case, he experienced 30 prone restraints in a 2-month period. I would argue that every one of those restraints was traumatic. Indeed, one day Andre was in prone restraints for about two hours. Is it any surprise that his relationships with his staff deteriorated? Why would he trust them? For Andre, his history of restraint has had a lasting impact on his ability to develop trust with caregivers. His decision to wear a helmet all day every day for 6 years speaks volumes as to how unsafe he felt in his environment. The fact that it took 6 years is a testament to how long the effects of trauma can last. He seemed to be telling us with his choice that he had decided to wear a helmet in order to protect himself from harm. Our family believes that clinical teams should analyze relationships and placements frequently to avoid situations that set up potential conflict. Supporting people with comfort rather than control creates a nurturing dynamic that fosters healthy relationships between vulnerable people and their caregivers.

Pay attention to transportation. People spend a great deal of time in vehicles, moving from place to place. Things happen in transit, just as they do in other environments, but incidents in vehicles may not come to the attention of the clinical team with the same level of detail as an event that occurs in the classroom, workplace, or residence. Events that occur on the bus on the way to school, or in a vehicle on the way to work, can have a profound impact on the person's entire day. It is important to collect and monitor data that reflects the transportation experience. Andre had many incidents where he was restrained in vehicles or where he became aggressive in vehicles. Many of these incidents resulted in bruises and abrasions. It required a careful examination of all of the details

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of Andre's transportation needs including spatial considerations and safety concerns before accommodations were made that made a difference. Supporting people with comfort rather than control creates a nurturing dynamic that fosters healthy relationships between vulnerable people and their caregivers. As Trader et al. (2017) pointed out, there is no evidence base for the therapeutic use of restraint.

Give people adequate space. When Andre is upset and unable to adequately communicate his feelings to those around him, he lashes out at others or will bang his head on a hard surface. Sometimes the trigger for him and others like him is the fact that, at that moment in time, he needs to have more space around him. He needs a safe space where he can get himself together on his own terms in order to appropriately join the group when he is ready to do so. For Andre at home, that space is his bedroom. He is most successful when he has the option of calming down in his bedroom when he becomes upset. Yet it is very common to find classrooms and residences that require many people to function harmoniously in a small space. For people without challenging behaviors this may be a workable situation. But for individuals who could act aggressively, the space limitations are creating conditions in the environment that escalate rather than de-escalate (Shukla-Mehta & Albin, 2003). Is it any wonder that a behavior that might be easily managed in a large space suddenly becomes an emergency in a small space?

Andre has had difficulty in vehicles and confined spaces with lots of people. When he is allowed more space in a vehicle, and when he has freedom to move away from crowds, he feels at ease and is able to enjoy gatherings without stress. When an individual like Andre becomes aggressive and begins to lash out in a small space, there is nowhere to move others in order to maintain safety. There is no semblance of a safe space for anyone, and the pressure of maintaining safety in a tight space can push an incident toward a physical intervention.

Our family recommends that progress could be made towards eliminating restraints if professionals were to re-think the spaces where people learn, work, live, and play with a focus on ensuring that people who need it are allowed enough space to feel comfortable and safe.

2. Strategies During a Crisis to De-Escalate Situation

Examine *imminent risk*. Take a careful look at the concept of imminent risk. It is important to closely examine the factors that impact safety (Alliance to Prevent Restraint, Aversive Interventions, and Seclusion [APRAIS], 2008; Huckshorn, 2004). Safety management requires the use of good decisions that balance the needs of all people in the environment. This discussion is not intended to call into question a carefully measured intervention as a response to an emergency. Rather, our family is hoping to encourage a critical and realistic analysis of the potential for harm before a decision is made to put hands on an individual. Andre had instances in one setting where he was put into prone restraints for throwing his lunch, or clearing a task off a table. Is throwing a lunch so dangerous that it warrants an intervention as dangerous as a prone restraint? If Andre clears a task off a table, is a restraint an appropriate measure to maintain safety? Immediately putting him in a restraint as a result of an outburst is as impulsive as the outburst itself. A more realistic assessment of imminent risk might have led to a very different outcome in Andre's classroom. It is important to be mindful of the safety risks that are introduced into a situation when physical interventions occur (APRAIS, 2008). When people are repeatedly restrained or secluded, the environment can easily become one where takedowns are routine and the culture is one of fear rather than support. This does not benefit anyone in the room. Indeed, the long-term consequences of the physical interventions could potentially drive psychological wedges between the teachers or staff and the people that they support, possibly provoking future outbursts. Andre's restraint experiences in his classroom led to a rapid deterioration of his relationships with his caregivers. Would any of us want to live, work, or learn in such an environment? The intervention may be riskier than the initial behavior.

Often, alterations to an environment can remove many risk factors. Doing so removes risk from the environment before the fact, and an event that might have been perceived as an emergency can now be handled more calmly and with less risk to anyone. Andre, when upset, sometimes expresses his frustration by banging his head on the floor. One ingenious accommodation that has helped him in his adult home was the installation of a soft

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surface on the floor. Although it is still frightening when he is engaged in head banging, the environment has been made much safer due to the installation of the floor.

Take your time in a crisis. It is important to allow Andre time to self-regulate when he is upset. Although the first inclination might be to intervene when he becomes upset, there can be great merit in remaining patient. Nothing ups the ante in a crisis like putting a time limit on a resolution. Unless an environment has become dangerous, it is usually a good idea to just slow down. When Andre is upset, the most effective approach with him is to remain calm. If those around him become upset as well, then the situation is likely to become more unstable. The best approach is to reflect for a minute about possible de-escalation strategies. Often, caretakers can find ways to take some pressure off a situation by buying a little time from the next activity or even skipping the next activity altogether. Flexibility in the schedule promotes a more relaxed demeanor from everyone in a crisis and affords a more natural environment for recovery.

3. Strategies After Crisis

Debriefing. Debriefing of significant incidents is a critical tool for families (NASMHPD, 2011). The debriefing process should incorporate the unique insight that families have into the challenging behavior of their loved ones. For instance, after examining documentation connected to the prone restraints in 2005, our family learned that Andre had many restraints that were a result of his resistance to certain behavioral therapies. Other restraints arose from an insistence that Andre maintain eye contact with his staff. For a person with autism, eye contact can be difficult. When he objected in the form of an aggression, the stage was set for physical intervention.

Our family was not included in the debriefing process during the months when Andre experienced so many restraints. In fact, we only became aware that the restraints were occurring when we began to notice bruises and abrasions on his body. We feel like our family was not afforded the opportunity to stop the cycle of restraints in a timely manner. Our experience since he was removed from that setting has been remarkably different. Because our family had experience handling Andre's challenging behaviors ourselves when he lived at home, along with subsequent team work with clinicians in the children's psychiatric hospital and other settings, we have been able to provide some context to help his team to better support him in difficult moments without resorting to restraint.

Families should have access to a written account of the incident in question before meeting or conferring. Ideally, the family or advocate should have an opportunity to speak directly to the lead person involved with the restraint, just as an administrator would have an opportunity for a discussion with the lead person (NASMHPD, 2011). Our family has been most successful in obtaining a clear picture of an incident when we were able to have a conversation with people who were there. This needs to happen in a timely fashion, within 24 hours of the incident. This does not preclude schools or agencies from having an internal debriefing after an incident. It simply provides a more complete picture of the event to all involved, so that all voices are heard when program changes are decided upon following a significant behavioral event (Peterson, 2010). Although it may be true that many teachers, staff, and administrators may advocate for an individual, families can bring a different perspective and a deeper level of personal commitment to the table. The debriefing process should inform and guide future practice. Every restraint should move the clinical team to examine the individual's program (Huckshorn, 2004; LeBel, Nunno, Mohr, & O'Halloran, 2012; Peterson, 2010). Our family believes that the debriefing process for people with disabilities should meaningfully engage families and guardians with the clinical team to provide a clarity and context to significant incidents.

Collect and use restraint data to inform practice. Schools and agencies, along with state systems of care, must do a better job collecting and monitoring restraint and seclusion data (LeBel et al., 2012). Nothing is more powerful in advancing an argument than referencing compelling data that supports your position. Families and advocates for people with disabilities have struggled to persuade those in power to move toward a more humane system in large part because of a lack of accessible, disaggregated data that illustrates the demographics and circumstances surrounding restraints and seclusion. In Andre's case, we had difficulty convincing social workers, administrators, and lawyers that anything was wrong with his situation

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because of an absence of evidence in the form of data. Although some of his restraints had been documented, those restraint reports were not used in an effective way to monitor the frequency, duration, and impact upon Andre. These reports were on paper, and most often found their way to a drawer or file cabinet. There was no acknowledgement that something was wrong with the support plan. The restraints just continued day after day for 2 months. Data has no value unless it is used to make change. It must be thoughtfully analyzed and mined for valuable insights that can help to inform supports for those with disabilities.

The lack of evidence about the frequency of restraints throughout the developmental disability community results in a false impression in the general public that all is well in the treatment of individuals with disabilities, and that cases like Andre's are the exception rather than the rule. Without reliable data, we know very little of the important details that can tell us so much about restraint and how to stop it (Huckshorn, 2004; LeBel et al., 2012). Who is being restrained? What type of restraint? For how long? Were there injuries? In what context did the restraint occur? How often? By whom? Where? These and other questions can give us valuable insight that can move best practice forward without compromising confidentiality. This is a human rights issue that needs to be examined as such. In education, data is routinely collected, generating indicators to measure progress in a wide variety of areas. With analysis of this data progress is regularly measured and monitored. Why not include an indicator that measures progress toward reducing restraint?

In Andre's case, the lack of available data regarding restraints made it difficult for our family to make the case that the use of restraints was a problem that the system needed to address. The prevalence of paper reports rather than an electronic data collection system made it nearly impossible for us to put forward a compelling argument for change. Although an electronic system does not make paper reports unnecessary, it can facilitate more efficient and timely recognition of trends and areas of concern. Our family recommends that every effort should be made to collect and monitor restraint data electronically in order to supply the information necessary to achieve a reduction in restraints.

Everyone deserves a second chance. In our daily lives, we make mistakes and adjust or not, and life goes on. Why should it be different for people with disabilities? It is important for people who exhibit problem behaviors to be given opportunities for behavioral growth (APRAIS, 2008). Andre had a great deal of difficulty being transported in the community for quite some time when he was in his teens. There were those who said that it was not appropriate to take him out into the community because of safety concerns. It was only after much discussion and advocacy by a wise teacher, that it was determined that Andre did just fine if he had spatial accommodations inside the vehicle. Instead of limiting Andre's world by restricting his access to the community, he now felt safe in his environment while travelling. Doesn't that provide a brighter future for Andre? He needed a second chance to succeed.

Our family believes that restraints are an emergency measure and should never be used for anything other than a real emergency, not even for a moment. We feel that any physical intervention should end as soon as the environment becomes safe. It is important to allow an individual who is upset the same leeway that we would want for ourselves. Andre spent nearly two hours in prone restraints one day in school. Was it necessary for him to be held down that long? If I were to put myself in Andre's shoes and imagine what it would be like to be in a restraint with several people holding me against my will, and then imagine that I had stopped struggling but I was still being held, it would infuriate me. I can only imagine what it must feel like in real life. It feels punitive, and it would not seem to encourage growth. The person being restrained is not being allowed the opportunity to gain his composure in a shorter length of time. He is not being allowed a second chance.

Don't give up on anyone. Our family believes that every person with a disability should have the right to a life free from restraints. We feel that this right also extends to individuals who might be at great risk because of their behavioral challenges. Andre is a person who continues to challenge professionals because of his occasional aggressive outbursts and self-abusive behavior. However, his case also clearly demonstrates the benefits of a collaborative approach between families and professionals. He is like others who have baffled the experts in a school or agency and who are at risk of being restrained frequently. Our family's belief is that there is a great deal to be learned from people like Andre, and if a way is found to help in these

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challenging cases, then that knowledge can likely help others as well. Professionals who have exhausted their usual array of resources to solve problems would do well to venture outside of their comfort zones to bring new ideas to the table. Again, involving family can have the benefit of bringing new insights into conversations about individuals. No one has all of the answers. Our family recommends adopting a goal that every person, regardless of the severity of the behavioral challenges, live a life free from restraints. These people deserve a chance to live a healthy and fulfilling life.

Conclusion

Although many people who support individuals with challenging behavior have shown a commitment to avoiding restraints, the reality is that all too often difficult situations result in physical interventions. Unfortunately, these responses almost always create an even more dangerous environment. It makes sense to notice all of the aspects of every individual's life that make a person feel happy or frustrated. It seems logical to build on strengths while trying to identify and minimize areas of frustration for every individual with a disability. In order to move in a positive direction and decrease the likelihood of restraints, our family asks professionals to examine their respective roles in creating conditions where people can thrive in order to identify steps that can be taken to provide a safe and welcoming environment for all, free from physical interventions.

Finally, our family wants to acknowledge the fact that this work is difficult. We have great respect for those dedicated professionals who work with people who have difficulty managing their frustrations. Please accept these thoughts and recommendations from us as an act of collaboration. It takes great creativity to design a system of supports that promotes growth and safety for individuals who can be aggressive or self-abusive. Many of these people cannot effectively communicate their needs or wishes, yet they experience the same range of emotions, hopes, and dreams as any other person.

The intent of this article is to tell Andre's story and the recommendations included are from our perspective as his parents. We hope that our recommendations encourage dialogue and problem solving around the issue of restraining people with developmental disabilities. Our intent is to allow Andre's experience to help to shine a light on some important factors that can play a role in crafting such a system of support. In a very imperfect way, it feels to us like we are giving voice to Andre and others who are at risk for restraint. We are hopeful that readers of this article might feel prompted to take a fresh look at someone in their care after considering Andre's journey. If that process yields a new approach that helps another individual to live a safer and more productive life, then that is a fantastic outcome. We are confident that Andre would be pleased.

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Minimizing Restraint and Seclusion in Schools: A Response to Beaudoin and Moore

Virginia L. Walker and Sarah E. Pinkelman

Abstract

Increasing efforts have been made in the field of special education to identify positive, evidence-based practices (EBPs) to meet the needs of students who engage in problem behavior, with a major goal being to eliminate or limit the use of reactive measures such as restraint and seclusion (Snell & Walker, 2014). Various stakeholders, including families and self-advocates, have voiced concerns about the dangers of restraint and seclusion and the lack of protection afforded to students who engage in severe problem behavior. In the previous article in this issue of *Intellectual and Developmental Disabilities*, Beaudoin and Moore (2018) echo these concerns in their account of a family's experience with restraint as told from the perspective of a father whose son was subjected to restraint, resulting in a number of adverse short- and long-term consequences that affected the entire family. In response to Beaudoin and Moore, we provide readers with a brief review of the current status of restraint and seclusion in school settings and evidence-based strategies that can be used to address severe problem behavior and reduce the need for restraint and seclusion. For readers interested in exploring restraint and seclusion in greater depth, we suggest recent work by Trader and colleagues (2017). We also have outlined guidelines for behavior support planning that should be considered by various stakeholders as educators work toward establishing safe and supportive school environments that address a wide range of student behavioral needs.

Key Words: *Evidence-Based Practices; Function-Based Interventions; Positive Behavioral Interventions and Supports; Restraint and Seclusion*

The exact prevalence of restraint and seclusion among children and adults with intellectual disability and related developmental disabilities (IDD) is unknown. However, recent reports from the Government Accountability Office (GAO; Kutz, 2009) provide insight into cases of restraint and seclusion resulting in physical and psychological harm and, in some instances, fatalities among students in school settings. Restraint and seclusion are considered emergency strategies only to be used in cases in which students or other individuals are in imminent danger (Simonsen, Sugai, Freeman, Kern, & Hampton, 2014). For all other instances of problem behavior, educators should implement the evidence-based strategies outlined in a student's behavior support plan (BSP). Unfortunately, seclusion and restraint are too often relied upon as acceptable ways to "manage" or "deal with" severe problem behavior, as was the case reported by Beaudoin and Moore in their article.

Even when schools have well-established systems of supports and interventions to address student problem behavior, it is reasonable to expect that some students may engage in dangerous, high priority problem behavior, thereby requiring the use of emergency strategies to maintain safety within the school. In such cases, school teams must be equipped with the knowledge and skills necessary to develop and implement crisis plans in the event that such measures are needed. Furthermore, teams will need to establish a plan that clearly outlines the specific conditions under which practices like restraint and seclusion can be used should behavior escalate to a dangerous level (for specific guidelines, see Simonsen et al., 2014). Establishing and following such a plan is particularly critical given that many states and school districts have little to no guidelines regulating the use of restraint and seclusion (Butler, 2017).

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Implications of Seclusion and Restraint in Response to Problem Behavior

Using restraint and seclusion to address problem behavior can lead to serious consequences for both the students and school personnel. As documented by Beaudoin and Moore (2018), the use of these aversive, reactive behavior management techniques may result in trauma or further exacerbate existing mental health issues (Trader et al., 2017; Westling, Trader, Smith, & Marshall, 2010). Furthermore, and largely due to the reactive nature of restraint and seclusion, students will likely continue to engage in problem behavior, as restraint and seclusion procedures do not include strategies to teach the student prosocial alternative behaviors. It is also possible that students will develop new forms of problem behavior or existing problem behavior will increase in intensity as a side effect of restraint and seclusion. When punishment-based practices like these are used, the implementer and other conditions associated with implementation (e.g., the intervention setting) may become aversive to the student, potentially leading to problem behavior that results in escape or avoidance of the implementer or other aversive conditions. Finally, school personnel utilizing restraint and seclusion may inadvertently enter into a vicious cycle in which restraint and seclusion replaces implementation of interventions outlined in a student's BSP. Because restraint and seclusion often produce immediate effects (i.e., problem behavior decreases), the implementer is reinforced for utilizing the practice and is more likely to do so in the future instead of implementing BSP strategies that may produce less immediate effects.

Evidence-Based Practices

There is limited evidence supporting the effectiveness of restraint and seclusion for addressing severe problem behavior (Simonsen et al., 2014; Trader et al., 2017). In order to promote a positive and safe school environment, evidence-based practices (EBPs) must be available for students who engage in severe problem behavior so that the use of restraint and seclusion becomes unnecessary or is significantly minimized. In fact, special education law emphasizes the importance of positive behavioral interventions and supports (PBIS) in developing function-based interventions for students with disabilities who engage in problem behavior (IDEA, 2004). A wealth of literature clearly shows the effectiveness of PBIS in not only reducing problem behavior, but also increasing prosocial behavior for students with disabilities (e.g., Goh & Bambara, 2012). In addition, decades of research have provided professionals with a strong evidence base supporting the effectiveness and social validity of function-based interventions to address severe problem behavior among individuals with IDD in a variety of school settings (Goh & Bambara, 2012; Walker, Chung, & Bonnet, 2017). In particular, and emphasized under a PBIS framework, function-based interventions comprised of *multiple components* are advantageous in that the BSP addresses ways in which the school team can prevent problem behavior, teach replacement behaviors, and respond to problem behavior. In contrast, restraint and seclusion are reactive practices that fail to provide students with supports that improve the educational environment and that teach prosocial behaviors or other critical skills (e.g., self-management, coping strategies) necessary to succeed in the school setting. As noted earlier, this can lead to reoccurrence or worsening of problem behavior. A multicomponent approach often involves input and collaboration among a range of school team members, including family members, and focuses on a student's quality of life (Carr et al., 2002). As such, the BSP development process reflects the types of person-centered planning activities that are recommended by Beaudoin and Moore (2018).

An in-depth description of the features and development of multicomponent function-based interventions is beyond the scope of this article. However, we provide readers with a brief description of the general assessment and intervention development processes to provide context for those guidelines outlined later in the article. Initially, the school team conducts a functional behavior assessment (FBA) to identify the function of the student's problem behavior. At minimum, this process involves the following activities: (a) reviewing student records; (b) interviewing individuals who are familiar with the student; (c) gathering information through questionnaires (e.g., Motivation Assessment Scale; Durand & Crimmins, 1992); and (d) observing the student and collecting direct observation data on problem behavior and environmental events that precede and follow problem behavior (O'Neill, Albin, Storey, Horner, & Sprague, 2015). If the team is unable to determine the function of problem

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behavior through this descriptive process, a functional analysis (FA) may be utilized as a means to gather information necessary to develop a BSP. This more complex assessment process involves systematically manipulating the environment to intentionally evoke problem behavior, thereby providing the assessor with information necessary to make judgements about the behavioral function (Iwata, Dorsey, Slifer, Bauman, & Richman, 1982). Teams new to FBA and FA should recruit assistance from behavior analysts or other school personnel who have expertise in these extensive assessment procedures, as the effectiveness of the BSP hinges on this assessment information. Regardless of the assessment method (FBA or FA), the school team will utilize the results of the assessment to inform the development of a BSP comprised of function-based interventions.

Function-based interventions included in the BSP are designed to address the identified function of problem behavior by preventing problem behavior, teaching alternative behaviors, and responding to problem behavior and targeted appropriate behaviors (Bambara & Kern, 2005; O'Neill et al., 2015). A key feature of BSPs developed under a PBIS framework involves identifying supports that prevent problem behavior by improving conditions under which problem behavior occurs (e.g., eliminating or modifying specific events that seem to trigger the behavior). These supports should be offered in conjunction with other elements of the BSP. As the BSP is developed and throughout its implementation, school teams should regularly assess whether the intervention strategies outlined in the plan have good contextual fit, meaning the extent to which they align with the values, needs, skills, and resources available in the setting (Albin, Lucyshun, Horner, & Flannery, 1996). Contextual fit is essential to the effective implementation of student BSPs. If a BSP includes strategies that are not valued and deemed important, or if the staff do not have the skills and resources to implement a BSP, effective implementation is unlikely (if not impossible).

Future Directions

Minimizing the use of restraint and seclusion in school settings serving students with IDD is an arduous task that will require systems-change efforts. Earlier in this paper, we discussed assessment processes (FBA and FA) and evidence-based interventions (function-based interventions to prevent problem behavior, teach replacement behaviors, and respond to occurrences of problem behavior) that are effective in assessing and treating severe problem behavior. The goal is that the student's team conducts a FBA/FA, develops a BSP that is technically adequate and contextually appropriate, and then implements the plan to improve student behavior and quality of life and decrease instances of seclusion and restraint. Each of these steps (assessment, plan development, and plan implementation) is essential. Often in applied settings there is greater attention to assessment and plan development and minimal (if any) attention to implementation (Pinkelman & Horner, 2017). The effective implementation of EBPs is a challenging and complex endeavor that requires attention to more than just the interventions themselves (Fixsen, Naoom, Blase, Friedman, & Wallace, 2005). Teams must also consider a variety of relevant systems-level variables, particularly how staff will be trained and continually supported to implement the BSP and how data will be collected and reviewed to evaluate both implementation and student behavior (Pinkelman & Horner, 2017; Trader et al., 2017).

Staff Professional Development

Before staff can be expected to implement a student's BSP, they must be trained to do so. The goal is to train staff to implement interventions outlined in a student's BSP with high fidelity. Fidelity, also referred to as treatment integrity, refers to the extent to which interventions are implemented as planned (Gresham, Gansle, & Noell, 1993). Function-based interventions to address severe challenging behavior might look unlike other strategies staff are accustomed to implementing, and as such will require a good deal of training and coaching to implement with fidelity. Unfortunately, professional development provided to staff most often is characterized by didactic "one shot" workshops that are ineffective in training staff to successfully implement EBPs (Fixsen et al., 2005). Effective professional development requires that staff receive (a) information regarding the theory of the practice and rationale for use, (b) modeling of correct implementation, and (c) opportunities to practice implementation and receive feedback (Fixsen et al., 2005; Joyce & Showers, 2002; Parsons, Rollyson, & Reid, 2012).

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In addition, it is important that staff receive ongoing support in order to maintain high fidelity. Staff will certainly encounter unanticipated barriers that will impede their ability to effectively implement the strategies previously trained. It is crucial that systems are established to continually evaluate and support staff in implementation. Data on fidelity should be collected and reviewed regularly. When data demonstrate fidelity is low (more on this in the section below), teams must identify ways to better support staff in implementation. One potential way to support staff is through Implementation Planning (Sanetti, Collier-Meek, Long, Byron, & Kratochwill, 2015), which outlines an explicit process for adapting the intervention to the setting context, addressing logistical concerns, and identifying barriers to implementation and strategies to overcome those barriers. The Performance Diagnostic Checklist-Human Services (PDC-HS; Carr, Wilder, Majdalany, Mathisen, & Strain, 2013) is another tool that teams might find useful. Using the PDC-HS, teams can assess performance deficits and then plan for how they can provide support to improve fidelity of implementation. For more in-depth information on performance management, we refer readers to Daniels and Bailey (2014). This is an excellent text that describes how to effectively manage staff behavior in an easy-to-read format.

Monitoring Implementation and Student Behavior

Once the behavior support team develops a comprehensive BSP (i.e., one that is technically adequate and contextually appropriate) and staff members have been trained in implementation, the next step is to collect data. In addition to collecting data on occurrences of seclusion and restraint as recommended by Beaudoin and Moore (2018), it is essential that data be collected on the fidelity with which the BSP is implemented as well as student behavior. Data on fidelity allow the team to determine if the BSP is being implemented correctly, and data on student behavior allow the team to determine if the plan is effective (Detrich, 2014; Fixsen et al., 2005; Park & Pinkelman, 2017; Pinkelman & Horner, 2017). When behavior support teams review these two forms of data, there are four potential outcomes: (1) the BSP is not being implemented correctly and student behavior is not improving; (2) the BSP is not being implemented correctly and student behavior is improving; (3) the BSP is being implemented correctly and student behavior is not improving; or (4) the BSP is being implemented correctly and student behavior is improving (Detrich, 2014). Obviously, the fourth potential outcome is preferred, but it is not unusual for data to indicate otherwise. If the BSP is not being implemented as intended and student behavior is not improving, the team should work to improve the fidelity with which the plan is implemented using some of the tools outlined above, such as Implementation Planning (Sanetti et al., 2015), the PDC-HS (Carr et al., 2013), and other aspects of performance management (Daniels & Bailey, 2014). It is possible that, with improved fidelity, student behavior may also improve. If the BSP is not being implemented as intended and student behavior is improving, this should prompt the team to continue monitoring and closely examine the variables in the student's environment that may be producing the change in behavior. If data indicate the BSP is being implemented correctly and student behavior is not improving, the team should reconvene to revise the student's plan. Finally, if the BSP is being implemented with fidelity and student behavior is improving, the team should continue implementing and begin identifying a plan to fade supports (Detrich, 2014). It is more common that organizations collect data on student behavior, and collecting data on fidelity may seem like an extra and non-essential task. However, fidelity data are absolutely critical. If teams cannot ensure the BSP is implemented with fidelity, no judgments can be made as to whether the plan is improving student behavior.

Summary

In this article, we provide guidelines for addressing severe problem behavior that, if followed, could displace and eliminate restraint and exclusionary practices. To achieve this goal, we advocate that educational teams rely on EBPs. However, this is only possible if school personnel are equipped with the skills and resources necessary for implementing these complex interventions, in particular multicomponent function-based interventions. Furthermore, it is essential that school personnel closely monitor both fidelity of implementation and student outcomes to ensure the efficacy of BSPs. Finally, all who are concerned with providing a free

and appropriate public education to students with IDD must advocate for a continued and increased focus on establishing safe and positive school environments. To assure that supports are put in place that contribute to a better quality of life for students with IDD and challenging behaviors, the involvement of families in developing BSPs is vital. We believe that Mr. Beaudoin would have been able to tell a far different story about his son's and his family's experiences with educators and schools had evidence-based behavioral supports been introduced at an early age.

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Enclosed in this packet are the updated Oregon Trail School District's policies on the use of physical restraint and seclusion, corporal punishment, and important forms to support documentation. Please review the policies and procedures to be used when the use of physical restraint or seclusion is necessary. Key staff in elementary, middle, and high school levels have been trained using the Oregon Intervention System (OIS) training program.

If an incident occurs, please ensure that an incident report has been filled out. Parents need to be provided verbal or electronic notification of the incident by the end of the school day when the incident occurred. Copies of the incident report must be provided to the parent(s) or guardian(s) within 24 hours of the incident.

A debriefing meeting must be scheduled within 2 school days of the incident and must include all personnel of the school program that were involved in the incident, as well as the district OIS Oversight person. Parents must be invited to the debriefing meeting, and copies of the debriefing report must be provided to parent(s) or guardian(s) as well.

2016-2017 District OIS oversight person is Maria O'Meara

Oregon Trail School District
Incident Report for Physical Restraint/Seclusion

Physical restraint means "the restriction of a student's movement by one or more persons holding the student or applying physical pressure upon the student and does not include touching or holding a student without the use of force for the purpose of directing the student or assisting the student in completing a task or activity. *OAR 581-021-0550(3)*

Seclusion means the involuntary confinement of a student alone in a room from which the student is physically prevented from leaving. Seclusion does not include "time out" which means removing a student from a short time to provide the student with an opportunity to regain self-control, in a setting from which the student is not physically prevented from leaving. *OAR 581-021-0550 (6)*

Physical restraint or seclusion may be used by a trained staff on a student in a public education program only if: the student's behavior imposes a reasonable threat of imminent, serious bodily injury to the student or others; and less restrictive interventions would not be effective. An untrained teacher, administrator, school employee, or school volunteer may use reasonable force upon a student, when a student's behavior imposes a reasonable threat of imminent serious bodily injury to the student or others and trained personnel are not immediately available due to the unforeseen nature of an emergency circumstance. The use of force must be consistent with all provisions in *OAR 581-021-0553* and *OAR 581-021-0556 (9).*

Parents must receive verbal or electronic notification of the incident by the end of the school day when the incident occurred. Copies of this form must be provided to the parent(s) or guardian(s) within 24 hours of the incident.

Student Name:	Date of Birth: SSID:
☐ IEP ☐ 504 ☐ BSP	Grade: School:
Date of Incident:	Type of Incident: ☐ Restraint ☐ Seclusion
Time Restraint began: __________ ended:__________ Total time:__________________	
Time Seclusion began: _________ ended:__________ Total time:__________________	
Location of Incident: ☐ Classroom ☐ Hall ☐ Playground ☐ Cafeteria ☐ Other: ________________________	Behaviors that led to restraint or seclusion:

Behaviors directed at: ☐ Staff ☐ Peers ☐ Self ☐ Other: ______________________	Description of activity in which the student or other students were engaged in immediately preceding use of restraint/seclusion:

Thorough description of efforts made to de-escalate and alternatives to restraint/seclusion that were attempted:

Approved Training Program used for Physical Restraint:	Physical Restraint hold(s) used:
Why was the use of restraint/seclusion necessary?	How restraint/seclusion ended (check all that apply): ☐ Determination by staff member that student no longer required restraint/seclusion ☐ Intervention by administrator(s) to facilitate de-escalation ☐ Other (describe):
Student's behavior during restraint/seclusion:	Student's behavior after restraint/seclusion:

Description of any injury to student and/or staff and any medical or first aid care provided (as per district policy, if injury occurred complete separate forms as needed in addition to this form):

Location of Restraint: ☐ Classroom ☐ Hall ☐ Playground ☐ Cafeteria ☐ Other: __________________	Location of Seclusion (describe): ☐ Allows staff full view of student in all areas of the room ☐ Free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets

Staff Involved in Incident:					
Name:	Position:	Administered Restraint	Certified to administer restraints	Observed Incident	Responsible for continuous monitoring
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
		☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Name of Parent or Guardian contacted: ______________________________

Contact Method: ☐ Phone ☐ In Person ☐ Written Notice ☐ Other: ____________

Date of Contact: _______ Time of Contact: _______ Contact by: ____________

Documented attempt(s) to contact parent or guardian if unable to contact verbally:

____

Parent invited to debriefing meeting: ☐

Parental attendance is not required, but they must be invited.

A debriefing meeting related to the use of physical restraint or seclusion must be held within two school days of the incident and must include all personnel of the public education program who were involved in the incident and any other appropriate personnel. Written notes must be taken of the debriefing meeting, and a copy of the written notes must be provided to a parent or guardian of the student per OAR 581-021-0556 (4).

Oregon Trail School District

Physical Restraint and/or Seclusion Debriefing Report

A debriefing meeting related to the use of physical restraint or seclusion must be held within two school days of the incident and must include all personnel of the public education program who were involved in the incident and any other appropriate personnel. Written notes must be taken of the debriefing meeting, and a copy of the written notes must be provided to a parent or guardian of the student per OAR 581-021-0556 (4). The purpose of the debriefing is to review the incident and take any necessary actions to reduce the chances that such an incident will reoccur. Those attending the debriefing meeting shall have the opportunity to review the physical restraint/seclusion report documenting the incident. Parents must be invited to debriefing meetings and receive a copy of the debriefing report.

Student Name:	Date of Birth: SSID:
☐ IEP ☐ 504 ☐ BSP School:	Date, Time and Location of Debriefing:
Date of Incident:	Type of Incident: ☐ Restraint ☐ Seclusion
Debriefing Notes:	
Further action to be taken:	

Revised 9/21/2012

Team members present:		
Name:	Signature:	Title:

☐ Copy of *Incident and Debriefing Reports* sent to parents

Oregon Trail School District 46

Code: **JGAA**
Adopted: 6/11/07
Readopted: 8/13/12
Orig. Code(s): JGAB

Use of Physical Restraint and Seclusion Policy

The Board is dedicated to the development and application of best practices within the district's public educational/behavioral programs. It is the intent of the Board to establish a policy that defines the circumstances that must exist and the requirements that must be met prior to, during and after the use of restraint and/or seclusion as an intervention with district students.

Definitions

"Physical restraint" means the restriction of a student's movement by one or more persons holding the student or applying physical pressure upon the student. "Physical restraint" does not include touching or holding a student without the use of force for the purpose of directing the student or assisting the student in completing a task or activity. The definition of "physical restraint" does not include the use of mechanical, chemical or prone restraint of a student as these methods are prohibited by Oregon law.

Seclusion means the involuntary confinement of a student alone in a room from which the student is physically prevented from leaving. Seclusion does not include the removal of a student for a short time to provide the student with an opportunity to regain self-control, in a setting from which the student is not physically prevented from leaving.

"Serious bodily injury" means any significant impairment of the physical condition of a person, as determined by qualified medical personnel, whether self-inflicted or inflicted by someone else.

"Mechanical restraint" means a device used to restrict the movement of a student or the movement or normal function of a portion of the body of a student.

"Mechanical restraint" does not include:
- -A protective or stabilizing device ordered by a licensed physician; or
- -A vehicle safety restraint when used as intended during the transport of a student in a moving vehicle.

"Chemical restraint" means a drug or medication that is used on a student to control behavior or restrict freedom of movement that has not been prescribed by a licensed health professional or other qualified health care professional acting under the professional's scope of practice.

"Prone restraint" means a restraint in which a student is held face down on the floor.

The use of physical restraint and/or seclusion is only permitted as part of a behavioral support plan when other less restrictive interventions would not be effective and the student's behavior poses a threat of imminent, serious, physical harm to the student or others.

The use of physical restraint and/or seclusion in these-circumstances is permitted only for as long as the student's behavior poses a threat of imminent, serious physical harm to the student or others.

Except in the case of an emergency, only staff current in the required training in accordance with the district-designated physical restraint and seclusion training program will implement physical restraint or seclusion with a student. In an emergency, physical restraint and/or seclusion may also be used by a school administrator, teacher or other school employee as necessary when the student's behavior imposes a reasonable threat of imminent, serious bodily injury to the student or to others. The use of physical restraint/seclusion under these circumstances is only allowed so long as the student's behavior poses a threat of imminent, serious physical harm to themselves or to others. Staff shall constantly monitor any student being restrained or secluded within the district, for the duration of the intervention, whether in an emergency or as a part of a plan. Any room used for seclusion of a student must allow staff full view of the student in all areas of the room and be free of potentially hazardous conditions such as unprotected light fixtures and electrical outlets.

The Oregon Trail School District shall utilize the "OIS" (Oregon Intervention Systems) training program of physical restraints and seclusion for use in the district. As required by State regulation, this program includes behavior support, prevention, de-escalation, and crisis response techniques. Any program selected by the district must be in compliance with state and federal law with respect to the use of restraint and/or seclusion.

An annual review of the use of physical restraint and seclusion including a review of all district cases involving restraint and/or seclusion, shall be completed to ensure. Compliance with district policies and procedures. The results of the annual review shall be documented and shall include at a minimum:

1. The total number of incidents of restraint;
2. The total number of incidents of seclusion'
3. The total number of seclusions in a locked room;
4. The total number of students placed in physical restraint;
5. The total number of students placed in restraint and/or seclusion more than 10 times in a school year.
6. The total number of restraint and seclusion incidents carried out by untrained individuals;
7. The demographic characteristics of all students upon whom physical restraint and/or seclusion was imposed.

This report shall be made available to the Board and to the public at the district's main office and on the districts website.

At least once each school year, the public shall be notified as to how to access the report.

The district shall investigate all complaints regarding the use of restraint and/or seclusion practices according to the procedures outlined in district policy-(JGA 06/09/1997, 04/12/2004 and JHFE 06/09/1997, 04/12/2004).

The superintendent or designee shall develop administrative regulations to carry out the requirement set forth in this policy and to meet any additional requirements established by law related to the use, reporting and written documentation of the use of physical restraint or seclusion by district personnel.

END OF POLICY

Legal Reference(s):

OAR'S 581-021-0550
OAR'S 581-021-0553
OAR'S 581-021-0556
OAR'S 581-021-0559
OAR'S 581-021-0563
OAR'S 581-021-0566

Oregon Trail School District 46

Code: **JGA**
Adopted: 6/9/97
Readopted: 4/12/04, 6/25/07
Orig. Code(s): JGA

Corporal Punishment

Corporal punishment is any act which willfully inflicts or willfully causes the infliction of physical pain on a student. Corporal punishment is prohibited by Oregon law[1] and is not an acceptable practice for discipline in the Oregon Trail School District.

Corporal punishment does not include the emergency use of reasonable physical force by a school administrator, teacher, school employee, or volunteer as necessary to maintain order or to prevent a student from harming him/herself, other students, and school staff.

Corporal punishment does not include any physical pain or discomfort resulting from or caused by voluntary participation in an athletic competition or recreational activity, or physical exertion shared by all students in a teacher directed class activity, which may include, but is not limited to, physical education exercises, field trips, or vocational education projects.

Physical restraint or seclusion, when used as a part of a behavior support plan in a student's individual education program or Section 504 plan, which has been developed with parent participation, is not considered corporal punishment.

Procedures:

1. Any staff person observing another employee or volunteer using corporal punishment, physical discipline, or physical abuse is required to report it to his/her own supervisor and follow the district child abuse reporting procedure.

2. If temporary physical restraint is used, the involved staff members will complete a Physical Restraint Incident Report, notify their supervisor as soon as possible, and comply with the provisions of the district Physical Restraint and Seclusion policy and procedures.

END OF POLICY

Legal Reference(s):

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[1] *ORS 339.250(12)*

Legal Reference(s):

OAR 581-021-0061
OAR 581-021-0062

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bild Published for the British Institute of Learning Disabilities

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Restraint and Seclusion: The Perspective of Service Users and Staff Members

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Background Restrictive measures may have important physical and psychological consequences on all persons involved. The current study examined how these are perceived by persons with intellectual disabilities and staff.

Materials and Methods Interviews were conducted with eight persons with intellectual disabilities who experienced a restrictive measure and their care providers. They were queried on their understanding of the restrictive measure, its impact on the relationship, their emotions and alternative interventions.

Results Restrictive measures were experienced negatively by persons with intellectual disabilities and their care providers. Service users reported feeling sad and angry, whereas staff mentioned feeling anxious. Moreover, persons with intellectual disabilities appeared to understand the goal of restrictive measures (e.g. ensuring their own and others' safety) and identified alternative interventions (e.g. speaking with a staff member or taking a walk).

Conclusion This study sheds further light on how persons with intellectual disabilities and staff experience the application of restrictive measures. Debriefing sessions with service users and staff may help minimize negative consequences.

Keywords: intellectual disability, restraint, seclusion, service user views, staff views

Introduction

The use of restrictive measures is subject to several laws and regulations in Québec. Indeed, these measures may only be applied to prevent persons from harming themselves or others (*An Act respecting health services & social services 2012*, s 118.1). Restrictive measures can therefore be used when, for instance, a person risks falling because of a given medical condition or manifests aggressive behaviours (hitting, scratching, biting, etc.). The current study is concerned with the use of restrictive measures in response to aggressive behaviour.

For the purposes of this study, the definitions of the Ministry of Health and Social Services of Québec (MHSS; in French: Ministère de la Santé et des Services sociaux du Québec) were used. It defines restraint as a restrictive measure limiting a person's freedom of movement through the use of *physical force* (physical restraint) or *mechanical means* (mechanical restraint) or by the removal of an adaptive device. Seclusion is a restrictive measure in which a person is confined to a location for a given time and cannot leave this location freely (Gouvernement du Québec 2002a). Chemical restrictive measures were not examined in the current study.

Although restrictive measures are subject to laws and regulations, their use is not always adequate nor is it necessarily minimized whenever possible (Keski-Valkama *et al.* 2007). Restrictive measures have important consequences for those who receive them and those who apply them, even if used to protect the person and others. These impacts include potential physical injury to either party, as well as psychological repercussions such as distress, anxiety, anger or fear (Meehan *et al.* 2000; Sequiera & Halstead 2001; Fish & Culshaw 2005; Hawkins *et al.* 2005; Williams 2009). It is therefore important to further study how restrictive measures are perceived by those affected by their use.

Several studies concerning the perception of the use of restrictive measures have been carried out in psychiatric settings. Meehan *et al.* (2000) note that many patients report experiencing during seclusion psychiatric symptoms similar to those of prison inmates in solitary confinement (hypersensitivity to external

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stimuli, hallucinations, anxiety and fear). Moreover, some patients report feelings of fear, powerlessness and rage when restrictive measures are used and say they felt that the staff had acted against their will (Naber *et al.* 1996). Others also mention feeling that staff members had ignored them or not listened to them before and after the restrictive measure was used (Bonner *et al.* 2002).

Investigations focusing on care providers' perceptions of restrictive measures highlight the anxiety, anger and psychological distress experienced by staff during the application of physical restraint and seclusion (Sequiera & Halstead 2002, 2004; Bigwood & Crowe 2008). Psychiatric care providers also mention that restrictive measures are part of their work although they often feel uncomfortable when they must resort to them (Bigwood & Crowe 2008).

Restrictive measures may have a negative impact on the relationship between patients and staff (Meehan *et al.* 2000; Lee *et al.* 2003). Indeed, the two parties appear to disagree on when the use of restraint or seclusion is justified and whether these measures are effective (Outlaw & Lowery 1994; Duxbury & Whittington 2005). However, patients who received a restrictive measure are able to discern both the positive and negative effects of physical restraint (Chien *et al.* 2005; Duxbury & Whittington 2005). Patients' perception of the use and effectiveness of restrictive measures may depend on the attitudes and behaviour of staff involved in the application of the restrictive measure, as well as the quality of care provided by them (Chien *et al.* 2005).

Studies on restrictive measures carried out among persons who have intellectual disabilities (IDs) have primarily concerned persons with mild-to-moderate intellectual disabilities living in secure residential facilities or psychiatric hospitals (Sequiera & Halstead 2001; Fish & Culshaw 2005; Jones & Kroese 2006). To our knowledge, only one study has thus far involved persons living in a community residence (Hawkins *et al.* 2005).

Service users with intellectual disabilities are aware of the role played by restrictive measures in the care they receive (e.g. to avoid harming themselves or others, to avoid engaging in violent behaviour; Jones & Kroese 2006; Fish & Culshaw 2005). Moreover, users mentioned alternative measures that could play a similar role. For instance, improved communication with service providers and the use of medication are perceived as less intrusive solutions (Jones & Kroese 2006).

As with patients in psychiatric hospitals, service users with intellectual disabilities report physical and psychological symptoms following the use of a restrictive measure. These symptoms include physical pain, anxiety, psychological distress and anger (Sequiera & Halstead 2001; Fish & Culshaw 2005; Hawkins *et al.* 2005).

There are a number similarities and differences between how staff and service users perceive restrictive measures. Fish & Culshaw (2005) observed disagreement as to whether physical restraint was used as a last resort. Indeed, some service users felt that this measure had been used when another, less restrictive form of intervention would have been equally effective (e.g. discussing their feelings or spending time alone in their room). Moreover, staff may perceive a situation involving physical restraint less negatively than service users (Hawkins *et al.* 2005). Finally, unlike service users, care providers do not acknowledge that self-strategies may be useful in reducing aggressive behaviours and may therefore limit service users' opportunities to exercise personal control over the situation (Hawkins *et al.* 2005).

Although the results of studies conducted among service users with intellectual disabilities are informative, the limitations of these investigations must be considered. First, most studies investigated physical restraint but excluded mechanical restraint and seclusion. These other forms of intervention may be perceived differently by staff and service users. Second, three of the four studies cited were carried out in secure residential facilities. It is possible that persons living or working in these settings may perceive restrictive measures differently due to their frequent exposure to these interventions. In support for this hypothesis, in a study conducted in a high-security psychiatric setting, Jones & Kroese (2006) noted an absence of emotional content in their interviews with participants with intellectual disabilities. They explained this observation by service users' habituation to the experience of restraint in their residential environment.

The current study seeks to identify how service users with intellectual disabilities and staff perceive the use of restrictive measures (the reasons for their use, their perceived effect on service users and staff, etc.). Additionally, it aims to compare the views of persons with intellectual disabilities and staff concerning restrictive measures. Whereas the majority of studies on the perception of restrictive measures involving persons with intellectual disabilities were conducted in hospitals and psychiatric settings, this study was carried out among persons living and working in a community setting.

Materials and Methods

Participants

The project was approved by the Joint Research Ethics Committee for the Rehabilitation Centers for Intellectual Disability and Pervasive Developmental Disorders (JREC/RCID-PDD). Participants were selected from the sample of another study on variables relating to the use of restrictive measures among persons with intellectual disabilities (Mérineau-Côté & Morin 2013). This study sought to identify personal and environmental factors that relate to the use of restrictive measures with people with intellectual disabilities living in the community. Participants in this study received services from provincially operated rehabilitation centres offering specialized support services to persons with intellectual disabilities or autism spectrum disorders living in the community. All participants were at least 18 years of age and manifested aggressive behaviours as measured by the *Modified Overt Aggression Scale* (MOAS; Kay *et al.* 1988). Participants were invited to take part in an interview based on three criteria: (i) they had experienced at least one intervention that involved the use of physical or mechanical restraint or seclusion during the previous month, (ii) their level of functioning (oral expression and listening comprehension) enabled them to participate in an interview on restrictive measures, and (iii) they were living within a 3-h driving distance from Montréal. The primary care provider who worked with a selected service user was also solicited to participate in the interviews.

Twenty-eight participants met the inclusion criteria. Consent was obtained for 28.6% of potential participants. Reasons invoked for a refusal to participate, when mentioned, included the user's unstable state, his or her level of functioning or the staff member's lack of time to devote to the investigation. The final sample was comprised of three men and five women with intellectual disabilities who used the services of three rehabilitation centres in Québec. Participants were aged between 20 and 56 years ($M = 38.12$, $SD = 14.633$) and had a mild ($n = 2$), moderate ($n = 5$) or severe ($n = 1$) intellectual disability. During the previous month, five service users had experienced a physical restraint measure; two, a mechanical restraint measure; and five, a seclusion measure. Finally, six users were diagnosed with a mental health disorder, and five had received a physical health disorder diagnosis.

The final staff sample was comprised of eight female support workers working with people with intellectual disability. The two samples were purposive (Patton 2001), that is, participants were recruited on the basis of their willingness to participate in the study and discuss restrictive measures.

Measures

Qualitative data were obtained through semi-structured interviews examining participants' perception of the use of restrictive measures. Two interview schedules were designed, one for each of the service user and staff groups.

The interview carried out among persons with intellectual disabilities consisted of ten questions regarding the context of use of a restrictive measure; its effect on themselves; the emotions they experienced before, during and after the intervention; possible alternative interventions; and the perceived impact of the intervention on their relationship with their care provider. The structure of the interviews and questions was based on the interview schedule used by Hawkins *et al.* (2005) among persons with intellectual disabilities. The interview schedule was designed with a close attention to word choice and the form of the questions. Questions were open and formulated as simply as possible (e.g. they did not contain double negatives). Response choices were prepared for some questions but were only employed if the user did not know how to respond. The interview schedule also included introductory questions designed to promote a relaxed atmosphere and help the user to warm up to the interviewer. Concluding (wind-down) questions were included to end the interview on a positive note. To facilitate comprehension and responsiveness, the interviewer employed visual aids (e.g. faces expressing emotions, depictions of restrictive measures) as needed.

The interview schedule used with staff members included 16 open questions regarding the context in which a restrictive measure was used; the emotions experienced by the staff member before, during and after the intervention; emotions perceived in the service user during the intervention; possible alternative interventions; and the perceived impact of the intervention on their relationship with the service user. Both groups were interviewed by the principal investigator.

Procedure

Data were collected over a period of twelve months beginning in February 2010. The researcher identified participants who met the inclusion criteria within the

sample from Mérineau-Côté & Morin (2013)and provided this information to a resource person at the rehabilitation centre. This person made an initial request to the care provider. A care provider who agreed to participate then asked the service user verbally whether he or she would be willing to take part in an interview on restrictive measures. The researcher then contacted staff members to schedule the interviews.

All interviews were audio-recorded and took place at the service user's residence or at the centre, according to the wishes of the participant. Service users and their care providers were interviewed individually. On the day of the interview, the researcher again obtained consent by reading and signing the consent form with the interviewee. A procedure was put in place with the agency to provide support to participants if they experienced negative emotions in relation to the interview. All interviews were carried out in French. Interviews with service users lasted between five and 20 min ($M = 11.97$) depending on users' verbal ability and the level of elaboration of their responses. Interviews with staff members lasted between 20 and 45 min ($M = 28.78$). A research assistant listened to 20% of the interviews (three for each group) to verify that the interview schedule was followed. For interviews with persons with intellectual disabilities, 39% of questions were asked as indicated in the schedule and 61% had been reformulated by the interviewer to adapt to the interviewee's level of listening comprehension. Concerning interviews with staff, 91% of questions asked conformed to the interview schedule and 9% were reformulated by the researcher.

Data Analysis

Interview transcripts were analysed based on a method inspired by a model from L'Écuyer (1990) and writings by Van der Maren (2004). The analysis consisted of six steps. (i) Interviews were transcribed verbatim by a research assistant. (ii) The researcher read each transcript twice to become familiar with its contents and to inform the creation of categories for the coding grid. (iii) The text was segmented into units of meaning by the researcher. Units of meaning are words or sentence fragments that have a complete meaning unto themselves (L'Écuyer 1990). (iv) A coding grid was constructed to classify units of meaning according to larger themes or categories. *NVivo* (QSR International, Cambridge, MA) was used to facilitate the construction of the coding grid and the subsequent classification of materials. The grid was constructed on the basis of reference texts and the initial readings of the transcripts in the second step. To maximize the validity and accuracy of the coding grid, it was used on a first transcript by both the interviewer and a research assistant. The resulting discussion served to clarify the categories to be used in the final coding grid. (v) The principal investigator analysed all transcripts by assigning a code (category) to each unit of meaning, thereby facilitating the description of the materials. To further increase the validity of results, 25% of materials were cross-coded by a research assistant. Inter-rater agreement was computed using the formula: number of agreements/number of agreements and disagreements 100, yielding a 78% rate of agreement. (vi) Finally, the description of the data emphasized important points in relation to the goals of the study.

Results

Figure 1 provides a graphical overview of the results of this study. It should be noted that this figure does not reflect formal conceptual model and, as such, does not display relationships that may exist between the depicted elements. Future investigations ought to examine the presence and direction of these relationships.

Service users' experience

Perceived goal

Some users appeared to understand the goal of the restrictive measure. Indeed, when asked why the restrictive measure was used with them, 50% ($n = 4$) mentioned safety reasons or the reduction of aggressive behaviour. For instance, 'for the safety (…) of everybody' 'to calm me down (…) and breathe'. Two users also reported that the restrictive measure was a punishment and one said it had been applied because he was possessed.

Emotions

Users reported experiencing mainly negative emotions in relation to restrictive measures. The interviewer asked them how they felt before, during and after the restrictive measure was used. Three users mentioned feeling anger before the intervention. During the intervention, users said they felt sad ($n = 6$), angry ($n = 5$), afraid and tired ($n = 1$). For instance, a user stated: '(…) sometimes, I am angry'. Another user

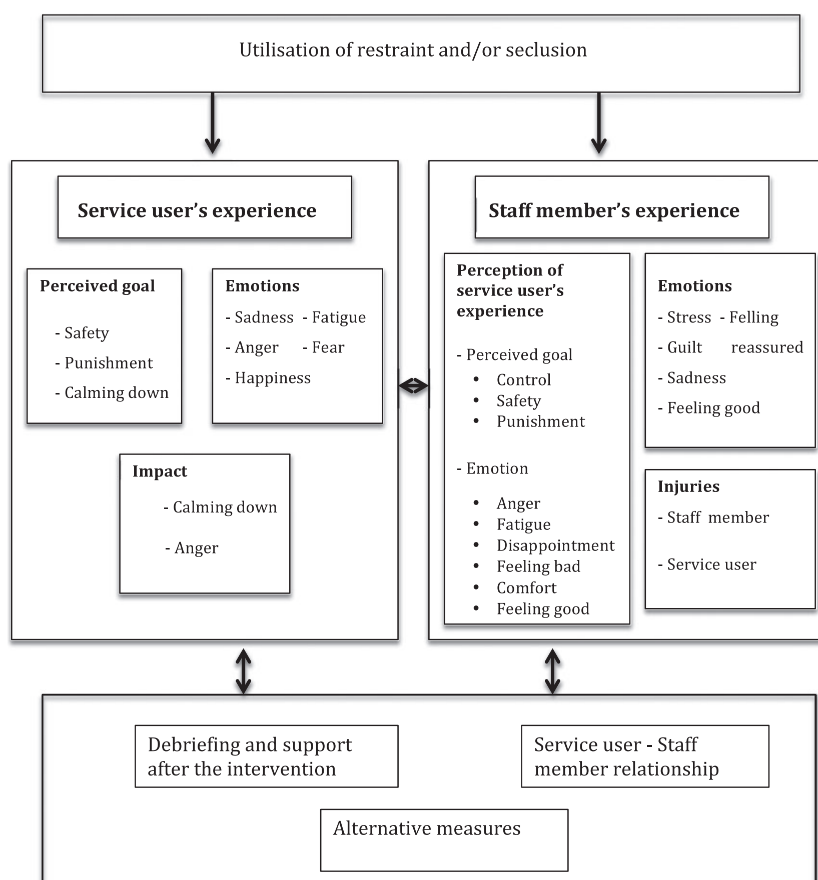

Figure 1 Service users' and staff members' perceptions of restraint and seclusion.

expressed feeling happy. After the use of the restrictive measure, some of the emotions expressed by users were more positive. Indeed, they said they were calm (n = 4), happy (n = 3), sad (n = 2) or tired (n = 1). For example, 'Interviewer: After, when it is over, are you happy or sad? User: 'Happy', 'I am happy to get out [of the room]'.

Impact

The majority of users (n = 6) reported that the use of a restrictive measure helps them become calmer: 'it's to calm me down', 'it's because sometimes, I need it to calm down'. However, among them one also reported that it increased aggressive behaviour: 'it makes me angrier'. The two other users did not want to answer the question.

According to care providers, the use of a restrictive measure leads in equal measure to an increase or a decrease in aggressive behaviour. Indeed, staff report that the intensity of the user's aggressive behaviour sometimes increases when a restrictive measure is applied (n = 6). Some mentioned that the user experienced anger during the intervention, which would explain the increase in the intensity of the behaviour (n = 2). Staff also reported that the restrictive measure helped users calm down (n = 6). However, some specified that the user calmed down only after a certain amount of time had passed (n = 1) or only if other interventions were used at the same time as a restrictive measure (e.g. speaking softly to the user, giving simple instructions, comforting the person) (n = 1). For instance, a care provider said that 'there are certain situations (…) she is so vulnerable that, no, I am not sure this is the measure that will help her calm down. Sometimes, I would say that yes (…) it will cut off all stimuli [e.g. decrease ambient noise and lighting] and place boundaries'.

Care providers' experience

Perception of service users' experience

Generally staff (n = 7) thought that users understood why restrictive measures were used with them. Five staff members specified that users perceived the measure as a way to help them control themselves when they cannot do it on their own and to ensure the safety of others: '(…) as a protective measure (…) to know we are there to stop him', 'For him, it is a means of self-control, but at the same time a way to comfort him (…)'. Three staff members felt that some users perceived the restrictive measure as a form of punishment: 'I think she sees it more as a punishment', '(…) she sees it as a punishment too, but she knows it is to avoid hurting others'.

According to staff, users may feel a range of mostly negative emotions when they experience a restrictive measure. They believe the users feel anger (n = 3), are tired (n = 3), experience disappointment (n = 2) or feel bad in general (n = 2). Some staff members also mentioned that users may feel good (n = 1) or comforted (n = 2) during the application of a restrictive measure: 'He feels good like this and that's what he asks for', '(…) what is important to him is that there are people who can restrain him'.

Emotions

Staff experienced various emotions in relation to the use of restrictive measures. Before the intervention, they reported having felt anxiety (n = 4), disappointment (n = 1) and a surge of adrenalin (n = 1). For instance, a care provider said: '(…) you know, when he weighs fifty to a hundred pounds more than you, even if you know there are two security officers and two others that are running towards you (…) but it's really stressful'. Staff members discussed experiences of stress (n = 4), sadness (n = 1) and guilt (n = 1) during the use of a restrictive measures. Another said she felt reassured because of the reduced risk of aggression during seclusion: 'of course it's more reassuring because there aren't any risks of aggression'. One staff member said she felt good because using restrictive measures is not problematic, and she only did so at her client's request. Staff identified feelings of stress (n = 2), fatigue (n = 2), sadness (n = 2) and disappointment (n = 2) following the intervention. A staff member also mentioned that they were safer after the measure had been used, and another said that she had sought her colleagues' approval about the intervention: 'me, I try to check, anyway, with my colleagues (…) was what I did okay?'

Injuries

The majority of staff reported sustaining superficial injuries (n = 5) such as bruises or cuts during the use of restrictive measures: 'Yes. Well, no, it's superficial; it's not a broken arm'. However, injuries seem more closely related to the client's aggressive behaviour than to the restrictive measure in itself: 'Well, in truth, it's not so much the restrictive measure as it is the aggression that led me to apply a measure [that resulted in an injury]'. One care provider mentioned having had a back injury as a result of the prolonged application of physical restraint. Two staff members said they had never been injured during an intervention that involved a restrictive measure.

Only two staff members mentioned having witnessed injuries among service users. One said the user had suffered from tendinitis in the shoulder following the use of physical restraint. Another reported that a user had friction-related injuries after wearing wrist restraints for an extended period of time.

Restraint and seclusion experience

Three important aspects of service users' and care providers' experience emerged from the interviews: the belief that alternative interventions could have been used, the impact of the intervention on the relationship between service users and staff members and the support received by staff members after the use of a restrictive measure.

Alternative interventions

Service users named several activities that could have been used in place of, or before resorting to, a restrictive measure. According to them, when they feel upset, they could write about it (n = 1), discuss it with someone (n = 3), take deep breaths (n = 2), participate in an enjoyable activity such as drawing or playing a video game (n = 2), go to their room and relax by themselves (n = 2) or engage in a physical activity such as running, throwing a ball or hitting a punching bag (n = 1). Two users mentioned 'taking a PRN' (service users employed this abbreviation to describe 'as required' medication) as an alternative measure.

Staff members also listed several interventions that could be used in place of, or before having to resort to,

restrictive measures. The most frequently mentioned alternatives were encouraging users to rest in their room or to engage in a quiet activity such as drawing or crafts ($n = 3$). Some care providers suggested speaking with users and helping them verbalize their emotions ($n = 3$). The use of 'as required' medication was mentioned by two staff members. Finally, staff also suggested that users could listen to music, put their hands in their pockets or use a stress ball. They also mentioned that care providers could use a visual timer and, in some cases, should seclude themselves rather than users.

Impact on the service user – staff member relationship

Staff highlighted both negative ($n = 6$) and positive ($n = 4$) consequences of restrictive measures on their relationship with the service user. Among possible negative repercussions, they mentioned that the service user may perceive the situation negatively, feel they were being punished, feel angry towards the staff or lose trust in their care providers. For one staff member, the use of a restrictive measure also had positive consequences such as an increased frequency of contacts with the user. In this case, the use of mechanical restraint had helped her engage in activities with the user and facilitated physical proximity because the mechanical device was used to prevent aggressive behaviours. Three staff members also mentioned that the intervention could be perceived in a positive light if they followed up on the incident with the user: 'I would tend to say that certainly the user can perceive (…) negatively (…) if the situation occurred I would insist on debriefing immediately afterwards'.

Support after the intervention

Most staff said they could speak with their department head or with colleagues after experiencing a difficult intervention ($n = 6$). Five staff members mentioned the possibility of using an employee assistance programme. Some said they could take a break ($n = 2$) or a day off after a trying intervention. Finally, a care provider mentioned that she would like a debriefing session to be carried out systematically, after each use of a restrictive measure. According to her, some staff members might not currently use the services available to them out of embarrassment or because the use of restrictive measures is perceived as routine.

On the whole, most staff members stated that they did not enjoy using restrictive measures but that these were sometimes necessary, as a last resort, to ensure the safety of all parties ($n = 6$): 'for me, it is a last resort'; 'I think it may be overused, but in some situations it is necessary'; 'I think these are exceptional measures that should not be generalized to all users who have severe behavioural disorders'. Three staff members also reported that these measures would be used less often if more resources were available, such as an increased number of care providers in the residence: 'we do what we can, but with very limited means'.

Discussion

As demonstrated in earlier studies, the majority of persons with intellectual disabilities appear to understand why restrictive measures are used (Fish & Culshaw 2005; Jones & Kroese 2006). However, despite understanding the event, persons with intellectual disabilities report experiencing negative emotions when a restrictive measure is applied (see also Hawkins *et al.* 2005). Only one service user mentioned experiencing positive affect. This can be explained by the fact that restrictive measures were used at this person's request, such as when he felt unstable and needed additional support. Restrictive measures may have a different impact on a person when used preventively, rather than as a response to aggressive behaviour. How service users perceive and understand the goals of restrictive measures, as well as the emotions they experience when one is used may indeed influence the impact it has on them.

Persons who manifest aggressive behaviours or are involved in interventions related to these behaviours are at greater risk of injury (Emerson 2002). Earlier studies reported numerous cases of psychological distress, injury or even death following the use of a restrictive measure (Meehan *et al.* 2000; Sequiera & Halstead 2001; Fish & Culshaw 2005; Hawkins *et al.* 2005). In the current study, only two care providers said they had witnessed service users being injured in this context. Although these occurrences are a point of concern, these results are nevertheless encouraging and are a tribute to recent efforts to raise awareness about the risks of restrictive measures (e.g. by the articulation of a ministerial orientation and other documents concerning the exceptional use of restrictive measures; Gouvernement du Québec 2002a,b, 2011). Additionally, the majority of care providers who participated in this study had received training on restrictive measures during the last few years. It is possible that this training sensitized them to these issues or instructed them in the use of safer intervention techniques. According to staff, the injuries

they themselves sustained during an intervention were mostly superficial, such as bruises or cuts. Moreover, they mentioned that the injuries were more directly related to the behaviours that led up to the intervention than to the restrictive measure. However, one staff member reported a back injury after the prolonged application of restraint. This is also a concern and raises questions about training and the safety of using restrictive measure in community settings.

As mentioned previously, several negative emotions surround restrictive measures. Anxiety, sadness and guilt were among the emotions that staff reported having experienced during the use of a restrictive measure. This observation is consistent with earlier studies. Indeed, care providers discuss feelings of anxiety (Sequiera & Halstead 2004; Bigwood & Crowe 2008), anger and psychological distress when using physical restraint or seclusion (Sequiera & Halstead 2002, 2004; Hawkins *et al.* 2005). Moreover, as was the case in the current study, staff in psychiatric settings state that restrictive measures are part of their work although they often feel uncomfortable using these measures (Bigwood & Crowe 2008).

Service users and care providers mentioned several alternatives to restrictive measures. Those most frequently invoked by service users were speaking to a staff member, taking deep breaths, or taking 'as required' medication. Although such medication is considered in the literature as a form of chemical restraint, users appear to perceive this form of intervention as less intrusive. It is also possible that care providers who perceive the use of medication as a preventative measure may propose it before applying another restrictive measure. This may explain how 'as required' medication is perceived by some users. Communication with staff and the use of medication were also perceived as less intrusive by participants in another study (Jones & Kroese 2006). The adoption of alternative interventions in response to escalated aggressive behaviour may minimize the use restrictive measures and influence how service users perceive the event, especially if they feel that the restrictive was applied as a last resort.

Some staff members ($n = 4$) reported that the use of a restrictive measure may have a positive impact on their relationship with the service user if debriefing follows the intervention. However, the majority of staff members ($n = 6$) said there could be negative consequences on the relationship, depending on how the user perceived (e.g. as a punishment) and responded to (e.g. with anger) the situation. It is possible that a person who feels anger towards a staff member will be more likely to manifest aggressive behaviour in the future than a person who does not (Sequiera & Halstead 2001).

Staff reported experiencing negative emotions when using a restrictive measure. They also highlighted the importance of following up on the intervention with the service user. Given the emotionally charged nature of the event, it may be appropriate for staff to benefit from a similar debriefing session and be provided with opportunities to discuss difficult incidents formally or informally. In the current study, although some staff said they could speak to a colleague or supervisor, one care provider said that others may attempt to minimize the situation and would thus be less likely to seek help. Therefore, providing staff with adequate support requires a greater awareness of the emotions that care providers experience during interventions involving restrictive measures.

These results re-emphasize the importance of carrying out a debriefing after a restrictive measure was applied (see also Hawkins *et al.* 2005). Indeed, persons with intellectual disabilities and care staff both experience negative emotions during the intervention. Having the opportunity to discuss these feelings may help prevent further negative consequences (Meehan *et al.* 2000; Needham *et al.* 2010). A debriefing session may also help persons with intellectual disabilities gain a better understanding of the goal of the restrictive measure. Furthermore, the person conducting the session could assess the user's emotional state and future needs (Needham *et al.* 2010). Debriefing would also provide staff members with an opportunity to express and discuss the emotions they experienced during the restrictive measure and the events that preceded it (L'Abbé & Soulières 2001).

Data obtained from interviews with staff and persons with intellectual disabilities highlight several similarities in how these groups perceive restrictive measures. Indeed, it appears that on the whole persons with intellectual disabilities understand why restrictive measures are used, which their care providers acknowledge. When asked about the impact of restrictive measures, both staff and persons with intellectual disabilities reported that these measures helped the person calm down. However, this observation must be tempered by concerns of social desirability for both groups. They may have stated that a restrictive measure reduced undesirable behaviours because they believed it was the answer expected of them. Indeed, persons with intellectual disabilities may have reported this because that was what their care provider had told them when the restrictive measure was used ('We will do this until you

calm down'). In addition, it is noteworthy that staff mentioned that aggressive behaviours often increased immediately after the restrictive measure was applied but decreased after some time had elapsed. However, it is important to recall that restraint and seclusion should only be used as a last resort when the safety of the person or others is threatened. These measures should not be used to reduce the frequency of aggressive behaviours.

The discourse of persons with intellectual disabilities and staff also presents certain discrepancies. Indeed, when asked about emotions experienced during the use of a restrictive measure, persons with intellectual disabilities gave more negative responses than did staff. Only one service user reported positive affect, although three staff members thought that persons with intellectual disabilities felt good during the use of a restrictive measure. This disagreement is consistent with what was reported by Hawkins *et al*. (2005). Again with respect to experienced emotions, six persons with intellectual disabilities reported being sad during the use of a restrictive measure, whereas staff said service users felt anger, fatigue or disappointment. This observed difference suggests that staff should pay attention for signs of sadness in persons with intellectual disabilities with whom a restrictive measure is used.

Among the limitations of this study, it must first be noted that only a small number of participants could be recruited as a result of the chosen research method (interviews). However, the information obtained advances the current understanding of restrictive measures and the consideration of the opinions of persons with intellectual disabilities. It should also be noted that the sample consisted of persons with mild or moderate intellectual disability who manifest aggressive behaviours and only of female direct care staff. This is likely to have influenced the obtained results and prevents their generalization to all persons with intellectual disabilities and all staff members who work with them.

Another limitation of the study is also linked to the interview method. Indeed, obtaining reliable and valid information from persons with intellectual disabilities may often be difficult as a result of their cognitive and communication deficits. A challenge encountered during interviews with persons with intellectual disabilities is response bias. To minimize the impact of this limitation, the current study observed recommendations made by Prosser & Bromley (1998) concerning interviews with this population. The interviews were performed in private and in a location known to the interviewee, began and ended with easy questions and were comprised of open questions that employed a simple and concrete vocabulary. It was not deemed necessary to devise specific procedures to address instances of abusive practices that could be reported by participants. It was implicitly understood by the researcher and staff that the local complaints commissioner would be notified of any such reports, in compliance with MHSS guidelines. Abusive practices were not mentioned during any of the interviews conducted during this study.

A third limitation of the study concerns social desirability. This phenomenon occurs when persons act in a given manner to conform to social norms, even if this behaviour goes against their attitudes (Vallerand 1994). Social desirability applies both to persons with intellectual disabilities and to staff. Indeed, given the delicate nature of the topic of the current study, it is possible that some participants may not have expressed their opinions and, instead, provided responses they believed to be socially acceptable. To reduce social desirability to the extent possible, the interviewer clearly mentioned that the goal of the study was to understand how they perceived and experienced the use of restrictive measures, and not to pass judgment on the intervention or the behaviours that preceded it.

As mentioned previously, participants experienced all three types of restrictive measures (physical restraint, mechanical restraint and seclusion). However, perhaps as a result of the limited sample size, no differences were observed between their perceptions of these different types of measures. Also note that some users did not agree to answer certain questions, primarily those regarding incidents in which restrictive measures were used. This reluctance may be due the general emotional content of such discussions and their association with memories of unpleasant events and may have influenced the results obtained in this study.

To summarize, this study enabled a better understanding of how persons with intellectual disabilities and staff experience the use of restrictive measures. Additionally, it provided persons with intellectual disabilities with an opportunity to express their feelings and opinions on a difficult topic that concerns them directly. In agreement with previous findings, restrictive measures generally appear to be experienced in a negative fashion. It thus important to take into account the needs of persons with intellectual disabilities and staff, as well as the emotions they experience, when planning interventions and support. Furthermore, persons with intellectual disabilities perceive restrictive measures negatively in spite of their understanding of the situation. Although the MHSS has recently undertaken initiatives to raise awareness of this issue, the continuation of these efforts and the

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development of less restrictive modes of intervention remain a necessity. It would be pertinent to replicate this investigation among persons who received different types of restrictive measures (seclusion or physical, chemical or mechanical restraint) to determine whether perceptions differ as a function of the type of intervention. Moreover, future studies should also address differences in the perception of restrictive measures and in emotional reactions to their application in emergency situations (when the client manifests aggressive behaviour) or as a means of prevention (e.g., when requested by the client). Finally, future research should strive to integrate these findings and those of other groups (e.g. Hawkins *et al.* 2005) into a comprehensive theoretical model of the perception of restrictive measures used with persons with intellectual disabilities.

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Human Rights Committee Procedures

INTRODUCTION

Adventures with Autism believes that when institutions and HRC's develop and follow clear written procedures, there is an increase likelihood that the rights and welfare of human subjects will be protected. The purpose of this guidance is to assist staff at institutions and IRB's who are responsible for preparing maintaining written procedures.

POLICY

In the event that it is identified that a client requires restrictive procedures to preserve life and safety, the treating clinician must complete the attached document and submit it to the Chief Clinical Officer for approval. Unless there is risk of severe harm, the restrictive procedures must not be implemented until approval is received.

Any Functional Analysis procedure that requires an alone condition or has potential for harm regardless of how minor must be presented to the CCO in written format and approved in writing prior to implementation.

Any procedure listed above requires specific informed consent from parents/guardians. This shall be requested after completing the Internal Review Process. Clinical support is available to all clinicians for these meetings.

HUMAN RIGHTS COMMITTEE PROGRAM REVIEW REFERRAL

CLIENT'S NAME:

AGE:

DATE OF REVIEW:

HAS THIS PERSON BEEN REVIEWED BY THE HRC BEFORE?

DATE OF LAST REVIEW:

PERSON COMPLETING REFERRAL FORM & TITLE:

1. Give a description of the issue(s) being reviewed.

2. Give a brief description of the client's current day schedule:

3. Any medical concerns or problems?

4. Current Medications

5. Review of previously tried interventions and results

Completed request for either "Functional Analysis" or "Restrictive Procedures" and return to CCO.

Restrictive Procedures

Adventures with Autism uses restrictive procedures only in response to behavior(s) that constitute an emergency, even if written into a Behavior Intervention Plan.

Definitions:

Emergency: means a situation where immediate intervention is needed to protect a child or other individual from physical injury. Emergency does not mean circumstances such as: a child who does not respond to a task or request and instead places his or her head on a desk or hides under a desk or table; a child who does not respond to a staff person's request unless failing to respond would result in physical injury to the child or other individual; or an emergency incident has already occurred and no threat of physical injury currently exists.

"Physical Holding: means physical intervention intended to hold a child immobile or limit a child's movement, where body contact is the only source of physical restraint, and where immobilization is used to effectively gain control of a child in order to protect a child or other individual from physical injury. Definition found at Minn. Stat. § 125A.0941(c).

a. The term physical holding does not mean physical contact that:

i. helps a child respond or complete a task;
ii. assists a child without restricting the child's movement;
iii. is needed to administer an authorized health-related service or procedure;
iv. is needed to physically escort a child when the child does not resist or the child's resistance is minimal.

"Restrictive Procedures" means the use of physical holding or seclusion in an emergency. Restrictive procedures must not be used to punish or otherwise discipline a child

Restrictive Procedures Consent

In the event that physical holding or seclusion procedures are used in an emergency situation; parents will be notified via phone at soon as the situation is stable. The treating clinician or CCO should place this call. Clinicians should use the “Incident Reporting Procedure”.

If the treating clinician recommends the use of any seclusion procedures, restrictive procedures, or mechanical restraints, these must be approved by both parents/guardians and the Chief Clinical Officer.

Client: _____________________ ____________________________

Date: ___________ ________________

RATIONALE

(Add a description of the presenting problem including current frequency or rate, previously tried interventions, risk of harm, and other important information here)

PROPOSED RESTRICTIVE PROCEDURE:

COST BENEFIT ANALYSIS

COMPETING PATHWAYS FORM

		DESIRED BEHAVIOR	DESIRED MAINTING CONSEQUENCES
SETTING EVENT	ANTECEDENT	CURRENT BEHAVIOR	MAINTAINING CONSEQUENCE
		ALTERNATIVE BEHAVIOR	

PROPOSED DATE OF FIRST OFFICIAL REVIEW OF INTERVENTION: __________
PROPOSED DATE OF SECOND OFFICIAL REVIEW OF INTERVENTION: ________

TERMINATION CRITERIA: (What circumstances would result in immediate removal of this procedure – escalation, etc.).

CRITERIA FOR RECORDING THE USE AND EFFECTIVENESS OF THE PROCEDURE: (including a definition of success)

FADE OUT PROCEDURE:

POTENTIAL ALTERNATIVES THAT HAVE NOT BEEN ATTEMPTED:

APPROVAL OF CHIEF CLINICAL OFFICER		
PRINT LEGAL NAME	CCO SIGNATURE	DATE
CONSENT TO USE PROCEDURES		
CLIENT NAME		DATE
PARENT/GUARDIAN NAME	PARENT/GUARDIAN SIGNATURE	DATE
THIS CONSENT IS VALID FOR (.) MONTHS (NOT TO EXCEED 12 MONTHS)		

COMMENTS OF PARENTS/GUARDIANS:

Functional Analysis Consent Form

Client: _____________________ ____________________________

Date of Assessment: ___________ ________________

RATIONALE

This type of assessment will expose (client) to conditions that might set the occasion for aggression towards others, self-injury, and environmental destruction. These conditions are based on years of research indicating that positive and negative reinforcement (either social or non-social) are consequences that maintain problem behavior. By identifying which source of reinforcement accounts for (client)'s behavior, individualized treatment programs can be developed.

PROTECTION FROM RISK

(Client)s protection and risk reduction from harm will consist of session termination criterion following the (termination of session criteria), as well as modifications to the assessment format to minimize the number of incidences of target behavior (brief functional analysis with latency measures).

INFORMED CONSENT

Functional Analysis assessment described and explained to the ___________ clinical team on ______________________. The assessment process, risks, and benefits were explained to (client)'s substitute decision maker or legal guardian on ______________________.

SESSION LOCATION

Each session will be conducted at ____.

SESSION LENGTH

Each session will last ____ minutes in length.

CLINICIANS PRESENT

The Functional Analysis will be supervised by ___________________________ and supported by ____.

AUDIO/VIDEO RECORDING

Audio and video recordings __________ be completed during the assessment. Consents for audio and video recording were obtained from ____ on ______________________________.

ASSESSMENT CONDITIONS

Control Condition

Purpose: This condition is a control for all the test conditions because (client) is not alone, attention is available, and no tasks are presented. As a result, the target behavior should occur least often in the condition. If the aggression, self-injury, disruption or environmental destruction occurs at a high rate in the condition, it is possible that the behavior produces its own reinforcers and the alternative activities do not compete with problem behavior.

• *Antecedent conditions*: EXAMPLE: (the room should contain toys, leisure materials, and known reinforcers. The client should have free access to the items. At 30-second intervals the therapist should approach client and engage in conversation for 5-10 seconds, also the therapist should respond to any appropriate social behavior initiated by client).

• *Consequence*: EXAMPLE: (there are no consequences for problem behavior, except that attention should be delayed if problem behavior occurs just as attention is about to be delivered during following the 30-second interval).

Alone Condition

Purpose: This is a test for non-social or automatic reinforcement. If the aggression, self- injury, disruption or environmental destruction occurs at a high rate in the absence of social interaction, it is likely that the behavior produces its own reinforcers (as in self-stimulation)

• *Antecedent conditions*: EXAMPLE: (No therapist is necessary for this condition, if one is present, no social interaction occurs. The room should contain no toys, leisure materials, or reinforcers).

• *Consequence*: EXAMPLE: (The are no social consequences for the behavior (e.g., no comments or changes in facial expression).

Attention Condition

Purpose: This a test condition for social positive reinforcement. If the rate of aggression, self-injury, disruption or environmental destruction is higher in the condition than in others, it is likely that the behavior is maintained by attention as a consequence.

• *Antecedent conditions*: EXAMPLE (the environment should contain some toys or leisure materials, which are freely available during the session. Sessions begin with the therapist stating that he or she needs to "do some work", read the paper, chat with a colleague etc. effectively removing all interaction with client. From this point on the only interaction with client will follow the target behavior).

• *Consequence*: EXAMPLE (Following each occurrence of a target behavior the therapist approaches the client and makes a statement of concern, which can be paired wit brief physical contact. These interactions should last about 5-10 seconds. If the client continues to engage in the behavior during the interaction, the interaction should continue).

Tangible Item/Activity Condition

Purpose: This condition is a test for socially mediated tangible positive reinforcement. If the rate of aggression, self-injury, disruption or environmental destruction is higher in the condition than in others, it is likely that the behavior is maintained by a preferred item/activity as a consequence.

• *Antecedent conditions*: EXAMPLE (the setting will contain some preferred and leisure materials, which are NOT freely available during the session. During the session (client) will receive relatively constant fixed attention for the therapist. From this point on the only interaction with (client) will be with fixed attention. Any attempt to talk about or access the preferred item or activity will be physically blocked or verbally denied/refused).

• *Consequence*: EXAMPLE (Following each occurrence of target behavior, the patient will be allowed access to tangible items for approximately 30 seconds, at which time the items will be removed and the antecedent conditions re-initiated).

Escape Condition

Purpose: This is a test condition for social negative reinforcement. If aggression, self-injury, disruption or environmental destruction occurs most frequently in the condition, it is likely that behavior is maintained by escape from task demands.

• *Antecedent conditions*: EXAMPLE (the therapist begins the session by presenting a relevant task demand (educational, vocational, self-care etc.) to the (client). If he does not comply after 5 seconds, the therapist demonstrates the correct response (or provides a touch prompt). If (client) does not comply the therapist physically guides the client through the task. These instructional trials are repeated until the end of session. No other interaction between (client) and therapist will occur during session).

• *Consequence*: EXAMPLE (Following each occurrence of target behavior, the instructional trial (demand) is immediately terminated without comment from the therapist, and the next trial is delayed for 30 seconds)

ASSESSMENT FORMAT DETAILS

♦ ***Functional Analysis (Brief format)*:** if assessment time is extremely limited (e.g., only part of a day is available), reduce session length to 5 minutes and run as many sessions as time allows.

♦ ***Functional Analysis (Latency Measure)***: if problem behavior is rather severe and cannot be allowed to occur very often, run sessions as described above, but terminate the session after the first occurrence of problem behavior that occur, the measure will be the latency from the start of the session to the first occurrence.

♦ ***Functional Analysis of Precursors***: if problem behavior is rather severe and cannot be allowed to occur very often, precursors to problem behavior will be identified and sessions will be terminated when precursors are observed. The measure will be the latency from the start of the session to the first occurrence.

SIGNATURES

______________________________ ______________________________ Patient's Substitute Decision Maker Date (mm/dd/yyyy)

______________________________ ______________________________ Clinician

______________________________ ______________________________ Chief Clinical Officer

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ORIGINAL ARTICLE

An integrative review exploring the physical and psychological harm inherent in using restraint in mental health inpatient settings

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ABSTRACT: *In Western society, policy and legislation seeks to minimize restrictive interventions, including physical restraint; yet research suggests the use of such practices continues to raise concerns. Whilst international agreement has sought to define physical restraint, diversity in the way in which countries use restraint remains disparate. Research to date has reported on statistics regarding restraint, how and why it is used, and staff and service user perspectives about its use. However, there is limited evidence directly exploring the physical and psychological harm restraint may cause to people being cared for within mental health inpatient settings. This study reports on an integrative review of the literature exploring available evidence regarding the physical and psychological impact of restraint. The review included both experimental and nonexperimental research papers, using Cooper's (1998) five-stage approach to synthesize the findings. Eight themes emerged: Trauma/retraumatization; Distress; Fear; Feeling ignored; Control; Power; Calm; and Dehumanizing conditions. In conclusion, whilst further research is required regarding the physical and psychological implications of physical restraint in mental health settings, mental health nurses are in a prime position to use their skills and knowledge to address the issues identified to eradicate the use of restraint and better meet the needs of those experiencing mental illness.*

KEY WORDS: *inpatient, physical harm, physical restraint, Psychiatric hospital, psychological harm.*

INTRODUCTION

The primary focus of this review is to explore the physical and psychological impact of physical restraint for people receiving inpatient mental health care. International agreement has sought to define physical restraint, describing it as 'any action or procedure that prevents a person's free body movement to a position of choice and/or normal access to his/her body by the use of any method, attached or adjacent to a person's body that he/she cannot control or remove easily' (Bleijlevens *et al.* 2016; p. 2307). In the United Kingdom (UK), physical restraint has been defined as 'any direct contact where the intervener's intention is to prevent, restrict, or subdue movement of the body of another person' (Department of Health (DH), 2014; p. 26). For the purpose of this integrative review, physical restraint refers to 'any occasion in which staff physically hold

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the patient preventing movement, typically in order to prevent imminent harm to others, or self, or to give treatment, or to initiate others methods of containment' (Bowers *et al.* 2012; p. 31), and will exclude restraints by means of equipment and technology.

For some time, progressive and critical service users have expressed concerns about the legitimacy and potentially harmful impact of coercion and restrictive practices (Cusack *et al.* 2016; Duxbury 2015; McKeown *et al.* 2017; Rose *et al.* 2015). Such concerns have contributed to recent interest in models of trauma informed care, particularly to the extent to which services may retraumatize individuals (Bloom & Farragher 2010; Muskett 2014; Sweeney *et al.* 2016). The more radical survivor movements argue that the use of physical restraint reveals a more extensive or epistemic violence visited by psychiatric services upon individual (Lieggo 2013; Russo & Berseford 2014). Representative staff organizations have claimed restraint as an employment relations issue, with a mixture of progressive and regressive strategies (McKeown & Foley 2015).

BACKGROUND

Countries differ in their use of different forms of restraint, with containment methods used in some countries, yet not in others (Bowers *et al.* 2007); the same divergence has been evident in international policy (Royal College of Nursing 2008). However, in more recent years there has been an international policy shift to reduce restrictive interventions (McKenna 2016). For example, in the UK the DH (2014) has produced guidance for health and care staff in reducing restrictive interventions, whilst the National Institute of Health and Care Excellence (NICE) has issued guidelines on managing violence and aggression (NICE 2015). In addition to statutory organizations, campaign groups have also produced guidance to support individuals in challenging how restraint is used in mental health services (Mind 2015). Positive initiatives to promote patient-centred care, such as the 'Safewards' model, have also been implemented internationally (Bowers 2014).

Looking to a legal context, from a human rights perspective, the UN Convention on the Rights of Persons with Disabilities arguably renders aspects of compulsion and coercion unlawful (Minkowitz 2006; Plumb 2015). More precisely, Article 3 of the European Convention on Human Rights (ECHR) (2003) prohibits inhumane and degrading treatment, with poor practice in restraint falling within this category. Physical restraint can also be challenged under Article 8, respect for private life, and under Article 5, regarding deprivation of liberty/unlawful detention. Whilst specific international legislation around restrictive interventions will inevitably vary, in England and Wales the Mental Health Act 1983: Code of Practice (Department of Health 2015) identifies best practice in the use of restrictive interventions for people within mental health settings and detained under the Mental Health Act (1983, amended 2007). Additionally, from a safeguarding perspective, the Care Act (2014) in England sets out the legal framework for local authorities and partner agencies, in seeking to protect adults at risk of abuse or neglect. This would include any abuse or neglect experienced as a result of physical restraint.

Whilst international policy and legislation seeks to minimize restrictive interventions, research studies suggest physical restraint continues to raise concerns. For example, in the 10-year period, 2002–2012, there were 38 restraint-related deaths in the UK (Duxbury 2015) and approximately 1000 incidents of physical injury reported following restraint in 51 mental health trusts in England (Mind 2013). Regardless of policy, incidents of restraint in more recent years have increased, with 66 681 restraint episodes reported in 50 of 58 mental health trusts in England, 12 347 of which involved face-down restraint (Merrick 2016), leading to serious concern about its use (Care Quality Commission (CQC), 2017).

The misuse of physical restraint, deemed as abuse, also appears to be underreported by service users. Whilst some service users have reported the use of excessive force in their experiences of physical restraint (Brophy *et al.* 2016; Whitlock 2009), others believe they would not be taken seriously when reporting such practice (Cusack *et al.* 2016; Whitlock 2009). For some nurses, restraint is seen as a 'necessary evil' in controlling behaviour and preventing violence, thus leading to the normalization of restraint practice (Perkins *et al.* 2012). Evidence suggests at times restraint is used all too quickly, with nurses in one study referring to the use of restraint equating to a 'bouncer mentality' (Lee *et al.* 2003). Such beliefs and actions are often enmeshed within the culture of the ward and may contribute to the difficulties of introducing change (Pereira *et al.* 2006). In contrast, other studies have reported nurses expressing discomfort with using restraint, suggesting it can be demeaning for service users (Bonner *et al.* 2002; Duxbury 2002; Lee *et al.* 2003). These are important issues that nursing staff are well placed to address. Demonstrating compassionate attitudes and behaviours towards service users, and acting as positive

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role models for neophyte nurses and other healthcare staff may help to reduce, and subsequently eradicate, restraint (Bloom 2010). Chapman (2010) describes how this transmission of practices can occur in the course of forms of debriefing that serve simply to justify and reify the use of restraint, rather than learn constructive lessons.

Whilst research to date has reported on statistics regarding restraint, how and why it is used, and staff and service user perspectives about its use, there is limited evidence that directly explores the physical and psychological harm it causes to people being cared for within mental health inpatient settings. As a result, this integrative review aimed to explore this phenomenon.

Aim of the integrative review

The aim of this integrative review was to explore the physical and psychological impact of physical restraint on people admitted to mental health care inpatient settings.

METHOD

In undertaking this integrative review, both experimental and nonexperimental researches were included to ensure all findings were included (Whittemore & Knafl 2005). An integrative review was deemed as an effective approach, in that it 'reviews, critiques and synthesises representative literature on a topic in an integrated way' (Torraco 2005; p. 356). Cooper's (1998) framework for research synthesis was followed, which recommends a five-stage approach when undertaking a literature review: problem identification; literature review; data evaluation; data analysis; and presentation of results.

Problem identification

The focus of this review was to appraise and synthesize the available findings regarding the practice of physical restraint and the physical or psychological impact it has when used on those receiving care in mental health inpatient settings. Whilst Whitlock (2009) suggested underreporting of abuse caused by the misuse of physical restraint within mental health services, there appears to be a lack of comprehensive appreciation of how such abuse manifests in physical and psychological harm. Exploring and synthesizing the evidence relating to these phenomena may assist in developing a future research agenda.

Literature search

Using terms related to the components of the topic area (Table 1), five databases were searched, including CINAHL, EMBASE, PsycINFO, MEDLINE, and Cochrane. Hand-searching of reference lists within identified papers was also undertaken, resulting in further research for consideration. Journal searching, professional networking, and searches of the published work of authors, from key titles in the associated field of research, were undertaken to further ensure a detailed search was employed (Aveyard & Sharp 2013).

To avoid drift and further refine the search, inclusion and exclusion criteria were introduced (Aveyard 2010). As physical restraint can be used abusively, the year 2000 was deemed pivotal, as this was when the first national guidance attempting to define and address adult abuse in health and social care settings was published in the UK (Department of Health 2000). In the light of this, studies published from 2000 to October 2017 were included in the search. Other inclusion criteria were as follows: adults (over 18), mental health inpatient settings, physical and psychological harm as a result of restraint, and articles written in the English language. Exclusion criteria were as follows: those under 18, non-mental health inpatient settings, other forms of restraint, grey literature, and research papers in other languages. Qualitative, quantitative, and mixed-methods studies were included in the review. Given the lack of evidence to date, no systematic review was found. Figure 1 shows the literature search and papers retrieved during each phase of the search.

Data evaluation

There were three stages for screening the articles retrieved. The first stage included a database search through journal titles, where papers were set aside for further reading of the abstract. The inclusion/exclusion criteria were used to retrieve potentially relevant articles. The second stage involved reading the abstracts of each paper, again screening for relevancy, using the inclusion and exclusion criteria. The third stage involved reading the residual articles in full and making the final decision as to whether they were relevant for inclusion in the review. Although duplicates are generally automated within the database platforms, some duplicates within individual databases had to be manually removed (Clapton 2010).

In line with the next stage of Cooper's Framework (1998), papers which met the inclusion criteria were

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TABLE 1: *Search terms*

Setting AND	Perspective AND	Intervention AND	Evaluation
Hospital	Vulnerable adults	Behaviour control	Violence
OR	OR	OR	OR
Psychiatric hospitals	Adults at risk	Coercion	Abuse
OR	OR	OR	OR
Institutional setting	In-patient	Containment	Abuse of patients
OR	OR	OR	OR
Institution	Psychiatric patients	Control	Patient abuse
OR	OR	OR	OR
Institutional care	Mental health patients	Manual restraint	Abusive practice
OR	OR	OR	OR
Psychiatric unit	Consumer	Physical restraint	Sexual abuse
OR	OR	OR	OR
Nursing care	Client	Restraint	Trauma
OR	OR	OR	OR
Psychiatric nursing	Service user	Restraint physical	Risk
OR		OR	OR
Psychiatric ward		Restrictive intervention	Risk of injury
OR			OR
Psychiatric service			Adverse effect
OR			OR
Psychiatric unit			Adverse health care event
OR			OR
Psychiatric care			Adverse impact
Psychiatric setting			
OR			OR
Mental health ward			Elder abuse
OR			OR
Mental health setting			Harm
OR			OR
Mental health unit			Injury risk
			OR
			Physical abuse
			OR
			Safeguarding
			OR
			Safety behaviour
			OR
			Post-traumatic stress disorder

then appraised. The Critical Appraisal Skills Programme (CASP) tools were used for this purpose. Although the CASP was developed to critique a wide range of literatures (Whittaker & Williamson 2011), an appraisal tool was not available for mixed-methods studies. In the light of this, Riahi's (2016) modified CASP appraisal tool was applied. Following Cooper's framework (1998), methodological features were assessed for overall quality. Additionally, papers were evaluated using Walsh and Downe's (2006) Quality Summary Score. This quality assessment tool gives evaluations from A to D, ranging from no or few flaws to significant flaws compromising the quality of the study, and D-rated papers are deemed of poor quality, and therefore, a decision was made to remove any papers assessed as a D rating at this stage. However, no papers were rated as D, which meant that all papers at this stage were included in the review. Each paper was appraised by three reviewers, and a comparison of findings took place to ensure rigour and consistency.

Ten papers were finally included in the review (see Fig. 1). Of the 10 papers included in the final analysis, one was quantitative (Steinert *et al.* 2007), two were mixed-methods (Haw *et al.* 2011; Lee *et al.* 2003), and seven were qualitative studies (Bonner *et al.* 2002; Brophy *et al.* 2016; Knowles *et al.* 2015; Sequeira &

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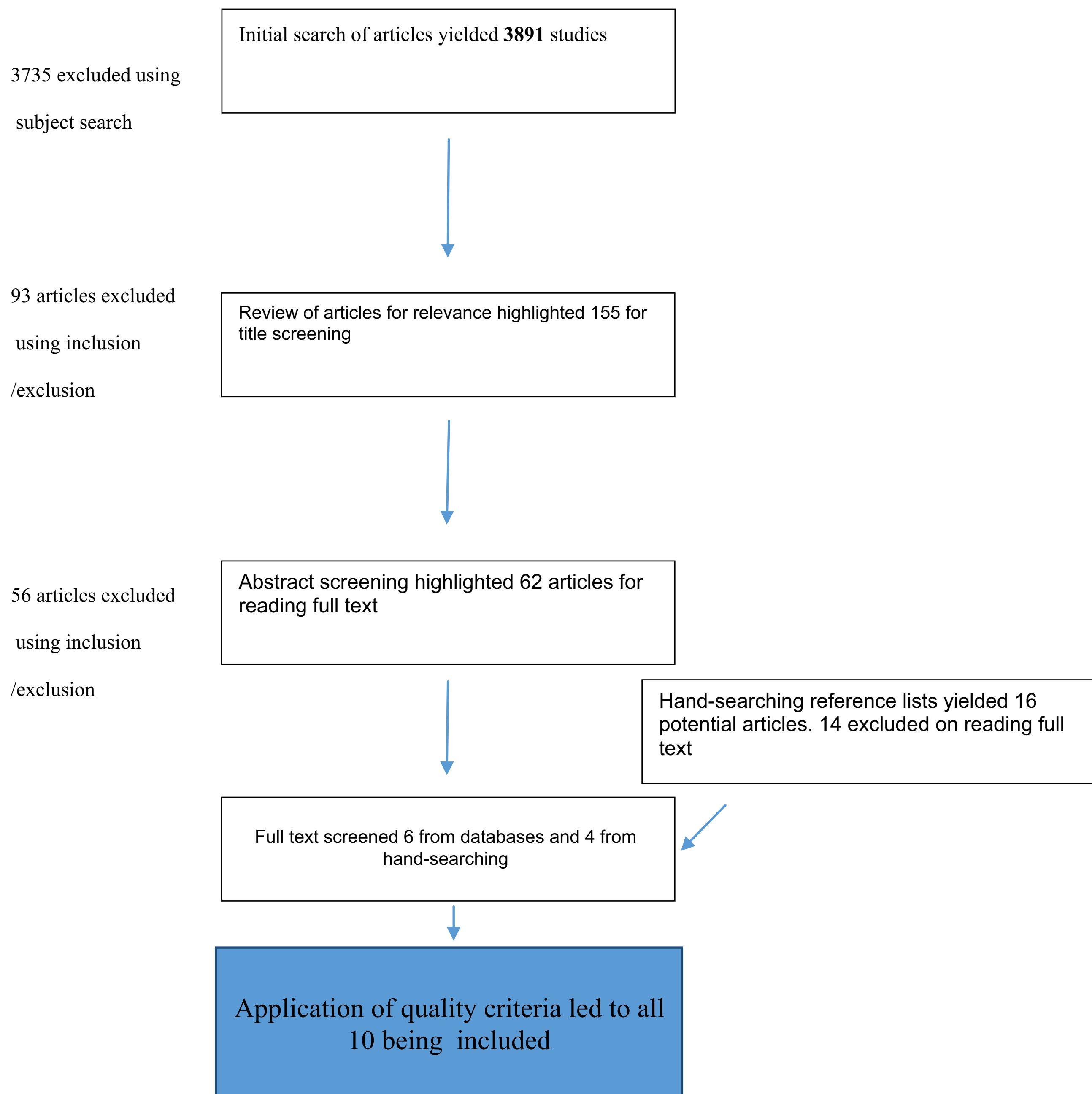

FIG. 1: *Flow diagram of literature search. [Colour figure can be viewed at wileyonlinelibrary.com]*

Halstead 2002, 2004; Wilson *et al.* 2017; Wynn 2004). Included in the seven qualitative studies, two papers reported on findings from the same study; however, each of these investigated differing participant perspectives, one being from the views of staff whilst the other exploring service user views. A decision was made to keep these separate for the purposes of this review, as each study identified some key differences within the themes.

Data analysis

Following the next stage of Cooper's (1998) framework, an analysis of data presented in the papers was undertaken. This encompassed constant comparison across the included papers to identify themes, patterns, and variations within the emergent findings, whilst splitting quantitative from qualitative findings. Constant comparison is acknowledged as an approach, which allows

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for systematic categories to form (Whittemore & Knafl 2005). A grid was devised to assist this process, and articles were read and reread, allowing distinct themes to emerge and variations to be acknowledged. In total, eight main themes emerged, with the focus of physical or psychological harm for users of mental health inpatient services who have experienced physical restraint. Table 2 summarizes the studies and the key themes arising within each paper, as well as the quality grading of individual papers.

RESULTS

All 10 papers involved primary research, emanating from different countries – one from Norway, one from Germany, one from Australia and seven from the UK. The papers include both service user and staff perspectives on the use of physical restraint. The possibility of restraint being used abusively is implicit in some of these papers (Brophy *et al.* 2016; Haw *et al.* 2011; Knowles *et al.* 2015; Wynn 2004). Although eight differing themes emerged related to the aims of this review, several themes were naturally interrelated. One example is the themes of power and control, and this will be elaborated upon within this review. The eight themes which emerged from this review are Trauma/retraumatization; Distress; Fear; Feeling ignored; Control; Power; Calm; and Dehumanizing conditions. These are visually displayed in Figure 2.

Trauma/retraumatization

The theme of trauma and retraumatization was identified in five studies (Bonner *et al.* 2002; Brophy *et al.* 2016; Sequeira & Halstead 2004; Steinert *et al.* 2007; Wynn 2004). Three (50%) of the participants in one study (Bonner *et al.* 2002), which sought to examine people's experiences following a restraint incident, reported how physical restraint retraumatized them due to past abusive incidents. For one participant, this had involved a previous experience of rape, whilst for another, physical restraint brought back memories of childhood abuse. Likewise, in Wynn's (2004) study, focusing on patients' experiences of physical restraint, two of three female participants and one male participant reported physical restraint had brought back memories of previous trauma. The male participant reported how difficult feelings were brought back from childhood experience in hospital, whilst both female participants described how physical restraint reignited memories of sexual abuse, with one reporting how it had reminded her of 'awful things that happened to me as a child' (Wynn 2004; p. 132).

Staff perspectives concerning the use of restraint and its impact of retraumatization were reported by Sequeira and Halstead (2004); however, in the same study other staff described how they were 'hardened' to the experience of restraint, with a significant number suggesting that they had no emotional reactions. Brophy *et al.* (2016), focusing on the lived experiences of people who had been restrained, suggested the trauma of actually being physically restrained was 'antirecovery' many participants raised concerns, not only about retraumatization, but how being restrained led to fear regarding future treatment. One participant, a carer, explained how her son was in fear of being readmitted to mental health wards, due to past restraint (Brophy *et al.* 2016).

Similarly, trauma was a concern raised by Knowles *et al.* (2015). Indeed, one patient was distracted within the research interview itself by the thoughts of previous restraint and reported how much of their time was occupied with vivid thoughts and dreams about restraint, which further suggests continued trauma because of the restraint episode itself.

Feeling ignored

Another emerging theme was the sense of participants feeling that their wishes and feelings were ignored by staff. In Bonner *et al.*'s (2002) study, three (50%) of the participants interviewed reported feeling distressed prior to restraint, but believed this was ignored by staff. One participant articulated how being ignored caused her to start shouting and screaming, and it was at this point staff restrained her. The psychological effects of being ignored, and her consequential behaviour, led her to experience feelings of shame and isolation following her restraint. Such feelings were seen as important issues by the participants, who believed if staff had intervened earlier in a more positive way, they might have de-escalated the situation.

In contrast, a study by Haw *et al.* (2011) reported on forensic inpatients' experiences and preferences for physical restraint, seclusion, and sedation. When asked about making an advance statement about physical restraint, some participants reported how physical restraint was unacceptable to them. An advance statement would allow a written plan to be made about how best to manage their behaviour if they became agitated. However, in this study 10.5% of participants stated how they had made an advance statement about

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TABLE 2: *Summary of articles*

Authors, year, country	Study type and analysis	Aim	Sample and setting	Main themes from physical restraint	Quality grading
Bonner *et al.* (2002) UK	Qualitative semi-structured interviews. Thematic analysis	To establish feasibility of using semi-structured interviews with patients following restraint. To gather information on factors which patients and staff felt helpful or unhelpful in their experience of restraint following restraint and to report on lived experiences of people involved	12 staff and six patients in an inpatient mental health ward in South of England	Trauma/retraumatization Feeling ignored Inhumane conditions Distress Fear	C
Brophy *et al.* (2016) Australia	Qualitative focus groups Inductive analysis (NVivo software)	To examine the lived experiences of service users and carers around the use of seclusion and restraint	30 mental health service users and 26 carers in four cities and one regional centre	Trauma/retraumatization Inhumane conditions Fear Control Power	C
Haw *et al.* (2011) UK	Mixed methods Qualitative thematic analysis Quantitative statistical analysis	To report on forensic rehabilitation of inpatients' experiences and preferences for physical restraint, seclusion, and sedation	57 patients in a forensic psychiatric setting	Feeling ignored Distress Dehumanization Power Calm	B
Knowles *et al.* (2015) UK	Qualitative interviews Thematic analysis	To examine the impact on the staff–patient therapeutic alliance	8 patients on a medium-secure unit	Power Dehumanization Trauma/retraumatization	C
Lee *et al.* (2003) UK	Mixed methods Qualitative thematic analysis Quantitative SPSS statistical analysis	To seek views of psychiatric nurses in their experience in use of restraint	338 psychiatric nurses in regional, secure, and psychiatric intensive care units in England and Wales	Dehumanization Power	C
Sequeira and Halstead (2002) UK	Qualitative (grounded theory). Semi-structured interviews	To examine the experiences of physical restraint procedures from a service user perspective	14 inpatients in a secure mental health setting	Power Distress Fear Control Calm	A
Sequeira and Halstead (2004) UK	Qualitative (grounded theory). Semi-structured interviews	To examine the experience of physical restraint by nursing staff in a secure mental health setting	17 nurses in a secure mental health setting	Trauma/retraumatization Distress Power	A
Steinert *et al.* (2007) Germany	Quantitative SPSS statistical analysis	To look at how seclusion and restraint might cause post-traumatic stress disorder and revictimization	117 mental health inpatients	Trauma/retraumatization	A

(*Continued*)

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TABLE 2: (Continued)

Authors, year, country	Study type and analysis	Aim	Sample and setting	Main themes from physical restraint	Quality grading
Wilson *et al.* (2017) UK	Qualitative thematic analysis	To improve understanding of restraint for both staff and patients, who have direct experience or have witnessed restraint	13 patients and 22 staff in adult mental health inpatient environments	Fear Power Dehumanization Distress	A
Wymn (2004) Norway	Qualitative grounded theory Interpretive analysis	To allow patient to share experiences of physical restraint	12 mental health inpatients	Trauma/retraumatization Distress Fear Control Power Calm	B

restraint, but there was no evidence of this in their case notes or care plans. This could be seen as another way in which service users are ignored. In the UK, the Mental Capacity Act (2005) is clear that advance statements should be considered part of the decision-making process within all healthcare settings. Of the 79 inpatients interviewed in Haw *et al.*'s study, 43 felt physical restraint should not be used at all, 38 suggested how talking might calm them down, and 39 participants felt sitting up during restraint would assist breathing. Haw *et al.* (2011) concluded it is best practice for patients to be fully involved in decisions made about their care as far as possible, perhaps going some way to demonstrate how their opinions and personal knowledge of self are valued and respected by staff.

Dehumanization

Another predominant theme in several of the studies reviewed was that of dehumanization in the perceived inhumane conditions present when people were restrained. One participant in Bonner *et al.*'s (2002) study described being left in urine soaked clothing for 3 hours following restraint, and reported being too ashamed to tell anyone. In Brophy *et al.*'s (2016) study, participants made links to poor practice, with feelings of being treated as 'subhuman' in the act of physical restraint, perhaps reinforcing any existing feelings of worthlessness.

In two of the studies (Brophy *et al.* 2016; Haw *et al.* 2011), patients found staff to lack empathy, with some describing staff as uncaring. Patients in Wilson *et al.*'s (2017) study echoed the feeling of being treated as 'subhuman', describing how they had they found physical restraint to be dehumanizing, with one participant feeling that they were not treated as 'decent human beings' (Wilson *et al.* 2017; p. 504).

Excessive force was reported to be used by staff during physical restraint. Lee *et al.* (2003) suggested restraint was being reported as a 'legal' way to hurt people, rather than being used as a last resort. In Lee *et al.*'s (2003) study, concerns were raised regarding joint locks and flexion being used to induce pain and achieve adherence. Haw *et al.* (2011) found that excessive force and pain were also reported, the former being a feature of care and the latter being the commonest sensation reported. In the same study, participants expressed concern that staff were punishing them and exerting power over them. Feeling 'punished' could reinforce feelings of self-blame, worthlessness, and/or low self-esteem, whilst experiencing powerlessness can lead to a person believing they are no longer

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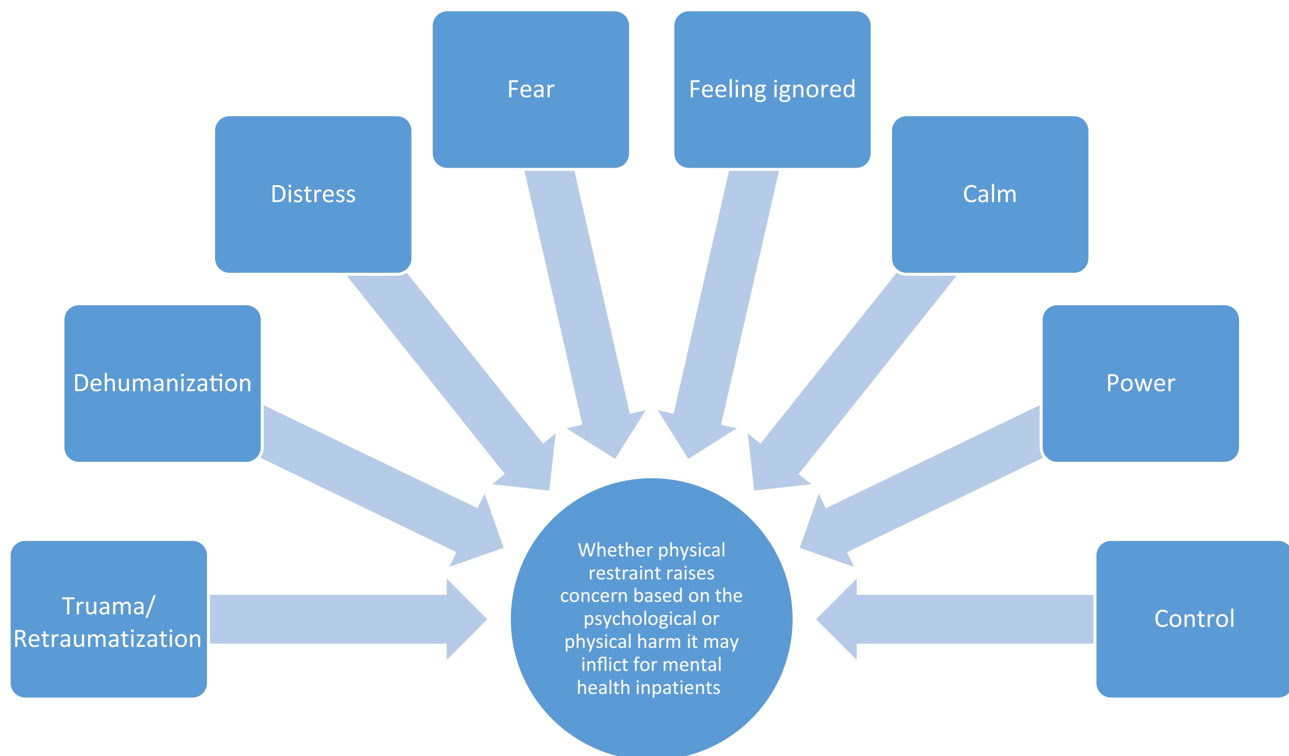

FIG. 2: *Emerging themes. [Colour figure can be viewed at wileyonlinelibrary.com]*

in control of their life. One participant said that they felt staff 'abused them' and told them that they were 'stupid'.

Similarly, concerns about excessive force were reported by Knowles *et al.* (2015), and patients reported that its presence during restraint made them feel abused, worthless, helpless, and demeaned. The potentially abusive nature of restraint and helpless felt by patients can also be linked with the imbalance and misuse of power, which is another theme within this review.

Distress

Given the previous theme, it is not surprising that the most common theme to emerge from the papers in this review was the distress caused by physical restraint. In Bonner *et al.*'s (2002) study, there was particular concern from two female participants when restrained by male staff members. One participant felt staff were going to kill her. Nurses also reported personal distress, describing feeling uncomfortable about undertaking restraint. This distress continued following restraint for both service users and staff, with fear of future incidents occurring in both groups (Bonner *et al.* 2002).

In Haw *et al.*'s (2011) study, 15 of the 57 participants reported how restraint brought about unpleasant thoughts, accompanied by feelings of humiliation and loss of dignity. Again the theme of distress resonates, in part, with the theme of dehumanization. In Wynn's (2004) study, participants reported how restraint harmed their integrity, making them feel anxious, angry, hostile, and distrustful of staff. Others reported that restraint had been unnecessary and that they had been unfairly treated. One participant went so far as to suggest restraint was abusive. In comparison, others felt it was necessary to contain a situation; however, no one perceived it to be positive (Wynn 2004).

In Wilson *et al.*'s study Wilson *et al.* (2017), the most common theme found was the distressing impact of restraint reported both by staff and by patients, particularly so when witnessed for the first time. In this study, one patient reported being 'horrified' (Wilson *et al.* 2017; p. 503) about the amount of physical restraint they had witnessed on the ward. However, two staff members in this study reported no emotional impact on themselves and suggested restraint was a necessary part of the job, perhaps implying that staff did not envisage a restraint-free environment (Wilson *et al.* 2017).

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Sequeira and Halstead (2002) found that most participants reported negative psychological impact, describing a sense of fear and panic at the possibility of restraint being carried out, and that 'something horrible was going to happen' (Sequeira & Halstead 2002; p. 13). Participants reported the way in which nurses spoke during restraint was particularly upsetting, with one participant reporting 'they talk and joke amongst themselves…You get angry, I get angry then' (Sequeira & Halstead 2002; p. 13). It was suggested nurses use laughter to reduce stress during physical restraint, whilst others reported no emotional response and working on automatic pilot during restraint (Sequeira & Halstead 2004). Gender and status appeared to play a role with regard to experiences of restraint. Several female qualified staff expressed substantial distress about restraint, whilst unqualified male staff more commonly reported a degree of detachment and indifference to service users being restrained. Some staff reported anger towards service users who were perceived as intentionally bringing about having to use physical restraint on a frequent basis (Sequeira & Halstead 2004).

Fear

Aligned to distress is the notion of fear, this also being a common theme across the papers reviewed. In Bonner *et al.*'s (2002) study, staff members' fear of patients was seen by service user participants to be an indicator for future restraint. Four of the staff in this study reported how planning and talking about imminent incidents, and knowing the patient, was important in their ability to manage potential incidents. Brophy *et al.*'s (2016) study reported that staffs' fear of service users was deemed a contributing factor in using restraint. This view was also expressed by a carer:

> Staff are frightened…. there's a culture of fear in Australia like fear of difference, I think it adds to it
> (Brophy *et al*. 2016; p. 8)

In Wynn's study (2004), participants reported being fearful of future restraint because of their previous experiences, with one female participant reporting how restraint itself made her feel increasingly scared and aggressive. These findings are in keeping with earlier research (Sequeira & Halstead 2002), whereby participants' fear of future restraint is based on their experience of previously being restrained and its long-lasting effects, such as poor sleep and nightmares. Similarly, fear, both during and following restraint, was also reported in Wilson *et al.*'s (2017) study, where a culture of fear was reported as being present throughout the patient journey. One patient described her fear of future restraint was because of a previous incident, when excessive force had been used by four staff members, as she had been dragged to the floor, on her knees, and taken to her bedroom. Although staff members in this study acknowledged fear felt by patients, a large proportion of staff also cited their own fear. This was particularly so when witnessing or carrying out restraint, for the first time. This suggests that restraint is a negative experience for both staff and patients.

Control

Brophy *et al.* (2016) found that restraint was deemed as a way to control patients, using excessive force. One participant reported the use of excessive force involving multiple staff. Furthermore, restraint was reported as a first, rather than last resort in responding to patients with mental health distress. Lack of de-escalation was linked to poor practice, the latter being the result of organizational cultures and staff attitudes (Brophy *et al.* 2016). Wynn (2004) found several participants reported that an approach, which would have affirmed their security in an unthreatening way, may have calmed the situation. Participants believed they were 'pushed' to defend themselves as a means of control. One participant commented 'I think things would have turned out better…if they had left me alone in my room' (Wynn 2004; p. 131). Other participants reported that they understood their behaviour needed to be controlled due to risks to themselves or others because of their distress.

Sequeira and Halstead (2002) found participants' loss of control over their behaviour left them feeling degraded and out of control. A subset of female participants felt that their agitation, before restraint, made them feel out of control, and they wanted staff to take control. The women in this subset also reported how they purposely brought about restraint to gain control over the way they were starting to feel. However, as discussed previously, staff felt anger at patients who they felt purposely brought about restraint (Sequeira & Halstead 2004).

Power

Power and its potential misuse were evident in the findings of several studies. Such power manifested in excessive force being used in restraint (Brophy *et al.*

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2016; Haw *et al.* 2011; Knowles *et al.* 2015), or when used as a first resort for managing a patient, to control them (Knowles *et al.* 2015; Lee *et al.* 2003).

Wynn (2004) took the ideology of control one step further, suggesting restraint to be an abuse of power, used by staff to display power over patients. Several participants reported that they were frightened of restraint occurring if they failed to follow staff directions. This fear continued after the restraint episode, as several participants expressed ongoing anxiety about restraint being used again. Serious concerns were raised by Lee *et al.* (2003) over the potential abuse of power by staff, with reports of them adopting a 'bouncer mentality'. Many patients alleged they had experienced physical pain or injury because of physical restraint, which also evoked worries about being injury.

Haw *et al.* (2011) also found participants believed restraint was used to punish them, and excessive power and undue force were used.

Similarly, Sequeira and Halstead (2002) reported restraint being used as a punishment, with several participants feeling this led to further violence and aggression, and therefore further additional restraint.

Knowles *et al.* (2015) suggested that the power imbalance between staff and patients might add to an abusive dynamic, with several patients in this study reporting how they viewed staff as powerful perpetrators, with patients being the victims. Patients also characterized restraint as barbaric, mediaeval, and torturous. In the same study, two patients reported being interviewed in seclusion by staff following physical restraint, during which time they were asked to admit fault for the restraint occurring, with one participant saying that they admitted fault for fear that they would not be released from seclusion, unless they did so.

Brophy *et al.* (2016) reported restraint made participants feel powerless and invoked a sense that they would not be believed if they reported abusive practice. In Brophy *et al.*'s study, the use of excessive force to prevent further escalation of a potential situation and combat risk was deemed as poor practice. The harm caused by this was perceived as being the result of the deep-rooted effect of excessive force and the breaching of human rights, particularly in respect of dignity. Carers also felt powerless, especially when not being listened to by staff, yet they believed they knew the patient best (Brophy *et al.* 2016). The harm viewed by service users and carers was deemed as long-standing and usually retraumatizing (Brophy *et al.* 2016).

Similarly, Wilson *et al.* (2017) found how restraint was considered a demonstration of power that staff have over patients, leaving them with a wholly negative experience, following restraint. One patient made comparisons to being in prison, referring to some staff being like 'prison wardens' (Wilson *et al.* 2017; p. 505). One staff member in this study acknowledged the patient–staff power dynamic, recognizing restraint as a 'symbol of strength and power that staff have over patients' (Wilson *et al.* 2017; p. 504).

Calm

A surprising theme that emerged from the review was the calming aspect of being physically restrained, which was highlighted in three of the studies. Wynn (2004) found that whilst participants reported anxiety, fear, and anger at being restrained, some participants reported how physical restraint had a calming effect. Female participants were found to instigate restraint to release feelings of upset and agitation, but only when being restrained by female members of staff (Sequeira & Halstead's 2002). A similar finding was reported by Haw *et al.* (2011), who suggested that whilst seclusion was reported to have a more calming effect than that of physical restraint, the latter was deemed to have the potential to de-escalate the situation and promote personal reflection. However, Haw *et al.* (2011) argue that the negative impact of physical restraint far outweighs any positive implications.

DISCUSSION

The emerging themes from this review suggest that physical restraint in some instances can and does lead to physical and/or psychological harm for those being cared for within inpatient mental health settings. Such harm can manifest in several ways. Service users can be traumatized due to the restraint itself or retraumatized following past trauma (Bonner *et al.* 2002; Brophy *et al.* 2016; Knowles *et al.* 2015; Sequeira & Halstead 2004; Steinert *et al.* 2007; Wynn 2004). Fear, and its potential for becoming a feature of care, from the perspectives of staff and service users before, during, and following restraint, was evident (Bonner *et al.* 2002; Brophy *et al.* 2016; Sequeira & Halstead 2002; Wilson *et al.* 2017; Wynn 2004). Further physical and psychological impacts of physical restraint include excessive control by ward staff, the physical harm being caused through physical pain or injury and the latter, psychological harm, being a feeling loss of control over

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one's life (Brophy *et al.* 2016; Knowles *et al.* 2015; Sequeira & Halstead 2002; Wynn 2004). Such physical and psychological implications can result in fear and anxiety around future restraint (Brophy *et al.* 2016; Knowles *et al.* 2015; Lee *et al.* 2003; Wilson *et al.* 2017; Wynn 2004).

Dehumanization was also a felt experience associated with restraint (Bonner *et al.* 2002; Brophy *et al.* 2016 Haw *et al.* 2011; Knowles *et al.* 2015; Lee *et al.* 2003; Wilson *et al.* 2017). Patients feeling ignored when they need support (Bonner *et al.* 2002) will have a negative psychological impact within the studies in which participants who experienced this described feeling 'subhuman', having a sense of 'otherness' both during and following restraint (Brophy *et al.* 2016; Knowles *et al.* 2015). The ignoring of individual's preferences through advance statements has been defined in legislation through the Mental Capacity Act (2005), and it is best practice for patients to be fully involved in their care as far as possible (Haw *et al.* 2011). The distressing experience of restraint from the perspectives of both patients and staff can impact on person's well-being (Bonner *et al.* 2002; Haw *et al.* 2011; Sequeira & Halstead 2002, 2004; Wynn 2004). For some participants within the studies, it was felt their life was threatened during restraint (Bonner *et al.* 2002). Conversely, for a minority of participants, physical restraint was reported as a positive intervention, being viewed as a way to calm them, letting others take control of their behaviour (Haw *et al.* 2011; Sequeira & Halstead 2004; Wynn 2004).

These findings are not unique in that other studies, in different settings and with different service user groups, report findings similar to those identified in this review. Studies of restraint in other types of settings, such as in learning disability facilities (Fish & Culshaw 2005; Jones & Kroese 2006), report how restraint techniques have the potential to cause physical and psychological harm (Parkes 2002; Parkes *et al.* 2011; Stubbs & Hollins 2011). Service users in other settings also reported the physical and psychological implications of harm as a result of physical restraint, particularly when it was misused. For example, physical harm related to being sat on, patients having their thumbs bent back, whilst psychological harm resulted from verbal abuse (Fish & Culshaw 2005; Jones & Kroese 2006).

Those who are restrained may be the most vulnerable service users. In a study by Hammer *et al.* (2010), 70% of patients who were secluded and restrained had histories of childhood abuse, reflecting the theme of trauma and retraumatization found in this current review. Furthermore, patients who experience seclusion and restraint most frequently have been reported as being 75 times more likely to have been subjected to physical abuse (Beck *et al.* 2008). Restraint use has been reported as a first response by staff, when they have perceived that their safety or the safety of others has been at risk (Duxbury 2002; Foster *et al.* 2007; Perkins *et al.* 2012), but evidence suggests an overestimation of risk based on service user behaviour (Foster *et al.* 2007). Additionally, fear based on incidents escalating to violence has led to an overestimation of the perceived threat and may prevent staff from looking for alternative ways of providing more therapeutic encounters (Duxbury 2002; Foster *et al.* 2007; Perkins *et al.* 2012). In a study by Perkins *et al.* (2012), nurses reported that restraint is a 'necessary evil' in controlling behaviour, and when staff consider individuals to be dangerous, aggressive, or difficult to manage, restraint can often be used in an arbitrary way (Gudjonsson *et al.* 2004; Keating & Robertson 2004). Likewise, such views can be part of a ward culture and this can prove challenging to change (Pereira *et al.* 2006). Good mental health nursing is predicated on therapeutic partnerships between service users and staff (Warne & McAndrew 2004), with good communication and interpersonal skills having the potential to prevent or minimize the need for restraint (Cusack *et al.* 2016). In the light of this and the evidence presented in this study, mental health nurses are well positioned to use their skills and knowledge positively to promote therapeutic engagement and eradicate physical restraint.

Limitations

A limitation of this integrative review is the small number of papers meeting the inclusion criteria. Generalization in other countries and settings may be limited, as restraint is practised differently across the globe which may favour different forms of restraint, such as equipment (Bowers *et al.* 2007), making comparisons difficult.

CONCLUSION

New insights have been gained through synthesizing findings from primary studies and providing new information, which adds to an existent, but small body of evidence regarding the physical and psychological implications of restraint from a service user perspective. Retraumatization, dehumanization, distress, fear,

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abuse of power, control – both wanted and unwanted – and feeling of being ignored were all important themes emerging from the data. All of these themes could be readily addressed by those working within mental health settings. There appears to be a gap in knowledge surrounding the narratives of service users who have experience of being physically restrained. This group of service users have unique and invaluable insight, and the future exploration of personal stories regarding the physical and psychological implications of physical restraint in mental health settings would be helpful in gaining a more in-depth understanding of this phenomenon and thus enable the quality of inpatient mental health care to be improved.

IMPLICATIONS FOR PRACTICE

Nurses within mental health services represent the majority of the workforce; therefore, their ability to engage service users as active partners in their care may reduce restraint-related incidents. In the light of this, education and training will have a pivotal role in seeking to reduce restrictive interventions by promoting initiatives, such as 'Safewards' (Bowers 2014) and 'Restrain Yourself' (Advancing Quality Alliance 2014), the latter being adapted from the six core strategies of restraint reduction (Huckshorn 2005). Such initiatives are fundamental to promoting positive therapeutic alliances between service users and staff, as well as managing challenging behaviour. Recognizing service users as active partners in their care should be the foundation of good practice. Involving service users in their own care planning has the potential to ensure they are empowered, promoting feelings of being more in control of their lives, and acknowledging their unique knowledge in relations to their illness experiences.

Likewise, further studies are needed to explore the perceptions of service users who have experienced physical restraint within mental health settings to improve services and better meet the needs of those experiencing mental distress.

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https://www.abainternational.org/about-us/policies-and-positions/restraint-and-seclusion,-2010.aspx

OAR 411-020-0002

Definitions

Unless the context indicates otherwise, the following definitions apply to the rules in OAR chapter 411, division 020:

(1) "Abuse" means any of the following:

***

(g) INVOLUNTARY SECLUSION. Involuntary seclusion of an adult for the convenience of a caregiver or to discipline the adult.

(A) Involuntary seclusion may include:

(i) Confinement or restriction of an adult to their room or a specific area; or

(ii) Placing restrictions on an adult's ability to associate, interact, or communicate with other individuals.

(B) In a facility, emergency or short-term monitored separation from other residents may be permitted if used for a limited period of time when:

(i) Used as part of the care plan after other interventions have been attempted;

(ii) Used as a de-escalating intervention until the facility evaluates the behavior and develops care plan interventions to meet the resident's needs; or

(iii) The resident needs to be secluded from certain areas of the facility when their presence in the specified areas poses a risk to health or safety.

(h) WRONGFUL USE OF A PHYSICAL OR CHEMICAL RESTRAINT OF AN ADULT.

(A) A wrongful use of a physical or chemical restraint includes situations where:

(i) A licensed health professional has not conducted a thorough assessment before implementing a licensed physician’s prescription for restraint;

(ii) Less restrictive alternatives have not been evaluated before the use of the restraint; or

(iii) The restraint is used for convenience or discipline.

(B) Physical restraints may be permitted if used when a resident’s actions present an imminent danger to self or others and only until immediate action is taken by medical, emergency, or police personnel.

***

(39) "Restraint" means:

(a) Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the individual’s body that the individual cannot remove easily, which restricts freedom of movement or normal access of the individual to the individual’s body. Any manual method includes physically restraining someone by manually holding someone in place.

(b) Chemical restraints are any substance or drug used for the purpose of discipline or convenience that has the effect of restricting the individual’s freedom of movement or behavior and is not used to treat the individual’s medical or psychiatric condition.

OAR 411-054-0005

Definitions

For the purpose of these rules, the following definitions apply:

(77) "Restraint" means:

(a) Physical restraints are any manual method or physical or mechanical device, material, or equipment attached to or adjacent to the individual’s body that the individual cannot remove easily, which restricts freedom of movement or normal access of the individual to the individual’s body. Any manual method includes physically restraining someone by manually holding someone in place.

(b) Chemical restraints are any substance or drug used for the purpose of discipline or convenience that has the effect of restricting the individual’s freedom of movement or behavior and is not used to treat the individual’s medical or psychiatric condition.

OAR 411-054-0060

Restraints and Supportive Devices

Residential care and assisted living facilities are intended to be restraint free environments.

(1) Restraints are not permitted except when a resident's actions present an imminent danger to self or others and only until immediate action is taken by medical, emergency, or police personnel.

(2) Supportive devices with restraining qualities are permitted under the following documented circumstances, the:

(a) Resident specifically requests or approves of the device and the facility has informed the individual of the risks and benefits associated with the device;

(b) Facility registered nurse, a physical therapist or occupational therapist has conducted a thorough assessment;

(c) Facility has documented other less restrictive alternatives evaluated prior to the use of the device; and

(d) Facility has instructed direct care staff on the correct use and precautions related to use of the device.

(3) Supportive devices with restraining qualities may be utilized for residents who are unable to evaluate the risks and benefits of the device when sections (2)(b), (2)(c) and (2)(d) have been

met. As of July 1, 2018 the process as identified in 411-054-0038 for Individually-Based Limitations must be followed for anything that meets the definition of restraint, including, but not limited to, supportive devices with restraining qualities.

(4) Documentation of the use of supportive devices with restraining qualities must be included in the resident service plan and evaluated on a quarterly basis.

Rules

DIVISION 60

STANDARDS OF PRACTICE, PROFESSIONAL METHODS AND PROCEDURES

824-060-0010

(1) In Oregon, the statutory definition of applied behavior analysis is stated in 676.802 (1)(a)-(b).

(2) For both behavior analysts and assistant behavior analysts, the Board adopts sections 1-9 of the 2016 “BACB Professional and Ethical Compliance Code for Behavior Analysts.”

(3) Licensed behavior analysts and licensed assistant behavior analysts who use restraints must have a policy in place for their use. A copy of the policy must be given to the client’s parent or guardian at the beginning of the service agreement. The policy will be one piece of information considered by the Board or Office in determining whether a restraint used on a client constitutes unprofessional conduct, negligence, incompetence, or a failure to conform to standards of practice under ORS 676.612(2)(j).

ADMINISTRATIVE RULE SCHEDULE

HEALTH LICENSING OFFICE
Behavior Analysis Regulatory Board

Date	Action	Time
Jan. 22, 2021	Board meeting to review/approve proposed rules	9 a.m.
Jan. 28, 2021	Interested parties/lawmakers noticed	
Feb. 1, 2021	Rule notice appears in Oregon Bulletin/public comment period opens	
March 1, 2021	Public comment period ends at end of hearing, which will be 9 to 10 a.m.	
July 16, 2021	Board meeting and approve permanent rules	9 a.m.
Aug. 1, 2021	Rules go into effect	

Please send all public comment or questions to:
Anne Thompson, Policy Analyst
1430 Tandem Ave. NE, Suite 180, Salem, OR 97301
anne.p.thompson@state.or.us . Work: (503) 373-1904

All meetings are held at the Health Licensing Office, 1430 Tandem Ave. NE, Suite 180, Salem, OR 97301, unless otherwise specified. Members of the public are invited and encouraged to attend all board and committee meetings. However, audience members will not be allowed to participate.

Items for Board Action

Oregon Health Authority

Issue statement

HEALTH LICENSING OFFICE
Behavior Analysis Regulatory Board

Issue

The Behavior Analysis Regulatory Board seeks to add an administrative rule regarding the use of restraints. The proposed administrative rule must have a rulemaking schedule approved as well.

Recommendation

Adopt proposed administrative rule and rulemaking schedule.

Legislation

81st OREGON LEGISLATIVE ASSEMBLY--2021 Regular Session

Senate Bill 355

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with presession filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Health Care for Paul Terdal)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Delays sunset of requirement that health insurance reimburse cost of applied behavior analysis for autism spectrum disorder.

Declares emergency, effective on passage.

1 **A BILL FOR AN ACT**

2 Relating to applied behavior analysis; amending section 22, chapter 771, Oregon Laws 2013; and
3 declaring an emergency.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1.** Section 22, chapter 771, Oregon Laws 2013, is amended to read:

6 **Sec. 22.** Section 2**, chapter 771, Oregon Laws 2013,** [*of this 2013 Act*] is repealed January 2,
7 [*2022*] **2030**.

8 **SECTION 2. This 2021 Act being necessary for the immediate preservation of the public**
9 **peace, health and safety, an emergency is declared to exist, and this 2021 Act takes effect**
10 **on its passage.**

11

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

Senate Bill 358

Printed pursuant to Senate Interim Rule 213.28 by order of the President of the Senate in conformance with pre-session filing rules, indicating neither advocacy nor opposition on the part of the President (at the request of Senate Interim Committee on Health Care for Paul Terdal)

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Changes authorization to practice for behavior analysis interventionists from registration to licensure. Allows applied behavior analysis professional to provide outpatient treatment for mental or emotional disorder or chemical dependency without patient's parental consent. Requires applied behavior analysis professional to report child abuse and to report prohibited or unprofessional conduct of another applied behavior analysis professional. Prohibits applied behavior analysis professional from practicing conversion therapy.

Extends requirement that health benefit plan provide coverage for treatment of autism spectrum disorder provided by applied behavior analysis professional to January 2, 2030.

Takes effect on 91st day following adjournment sine die.

A BILL FOR AN ACT

Relating to applied behavior analysis; creating new provisions; amending ORS 109.675, 419B.005, 675.850, 676.150, 676.815, 676.820, 676.825, 676.830 and 676.992 and sections 2 and 22, chapter 771, Oregon Laws 2013; and prescribing an effective date.

Be It Enacted by the People of the State of Oregon:

SECTION 1. ORS 676.802, 676.806, 676.810, 676.815, 676.820, 676.825 and 676.830 are added to and made a part of ORS 676.802 to 676.830.

SECTION 2. ORS 676.815 is amended to read:

676.815. The Health Licensing Office shall establish by rule criteria for the [*registration*] **licensure** of behavior analysis interventionists. The criteria must include, but are not limited to, the requirement that the applicant:

(1) Have a high school diploma, a modified diploma, a certificate for passing an approved high school equivalency test such as the General Educational Development (GED) test or a degree from a post-secondary institution;

(2) Be at least 18 years of age;

(3) Have successfully completed a state and nationwide criminal records check that requires fingerprinting;

(4) Have completed at least 40 hours of professional training in applied behavior analysis approved by the office by rule; and

(5) Receive ongoing training and supervision by a licensed behavior analyst, by a licensed assistant behavior analyst or by another licensed health care professional.

SECTION 3. ORS 676.820 is amended to read:

676.820. (1) An individual licensed under ORS 676.810 or [*registered under*] ORS 676.815 may practice applied behavior analysis.

(2) Only an individual who is licensed under ORS 676.810 or [*registered under*] ORS 676.815 may use the title "licensed behavior analyst," "licensed assistant behavior analyst" or "[*registered*] **li-**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

1 **censed** behavior analysis interventionist."

2 **SECTION 4.** ORS 676.825 is amended to read:

3 676.825. In the manner prescribed in ORS chapter 183 for contested cases **and in consultation**
4 **with the Behavior Analysis Regulatory Board**, the Health Licensing Office may impose a form
5 of discipline listed in ORS 676.612 against any person licensed [*or registered*] under ORS 676.810 or
6 676.815 for any of the prohibited acts listed in ORS 676.612 and for any violation of a rule adopted
7 under ORS 676.810 or [*676.815*] **676.820**.

8 **SECTION 5.** ORS 676.830 is amended to read:

9 676.830. A health benefit plan as defined in ORS 743B.005 may establish credentialing require-
10 ments for the provision of applied behavior analysis [*as defined in ORS 676.802*] by licensed health
11 care professionals [*as defined in ORS 676.802, by*] **,** behavior analysts or assistant behavior analysts
12 licensed [*by the Behavior Analysis Regulatory Board*] **under ORS 676.810** or by behavior analysis
13 interventionists [*registered by the Health Licensing Office*] **licensed under ORS 676.815**.

14 **SECTION 6.** ORS 676.992 is amended to read:

15 676.992. (1) Except as provided in subsection (3) of this section, and in addition to any other
16 penalty or remedy provided by law, the Health Licensing Office may impose a civil penalty not to
17 exceed $5,000 for each violation of the following statutes and any rule adopted under the following
18 statutes:

19 (a) ORS 688.701 to 688.734 (athletic training);

20 (b) ORS 690.005 to 690.225 (cosmetology);

21 (c) ORS 680.500 to 680.565 (denture technology);

22 (d) Subject to ORS 676.616 and 687.445, ORS 687.405 to 687.495 (direct entry midwifery);

23 (e) ORS 690.350 to 690.410 (tattooing, electrolysis, body piercing, earlobe piercing, dermal im-
24 planting and scarification);

25 (f) ORS 694.015 to 694.170 (dealing in hearing aids);

26 (g) ORS 688.800 to 688.840 (respiratory therapy and polysomnography);

27 (h) ORS chapter 700 (environmental sanitation);

28 (i) ORS 675.365 to 675.410 (sexual abuse specific treatment);

29 (j) ORS 678.710 to 678.820 (nursing home administrators and residential care facility adminis-
30 trators);

31 (k) ORS 691.405 to 691.485 (dietitians);

32 (L) ORS 676.612 (prohibited acts);

33 (m) ORS [*676.810 and 676.815*] **676.802 to 676.830** (applied behavior analysis);

34 (n) ORS 681.700 to 681.730 (music therapy);

35 (o) ORS 676.630 to 676.660 (advanced nonablative esthetics procedure);

36 (p) ORS 681.740 to 681.758 (art therapy); and

37 (q) ORS 676.665 to 676.689 (lactation consultation).

38 (2) The office may take any other disciplinary action that it finds proper, including but not
39 limited to assessment of costs of disciplinary proceedings, not to exceed $5,000, for violation of any
40 statute listed in subsection (1) of this section or any rule adopted under any statute listed in sub-
41 section (1) of this section.

42 (3) Subsection (1) of this section does not limit the amount of the civil penalty resulting from a
43 violation of ORS 694.042.

44 (4) In imposing a civil penalty under this section, the office shall consider the following factors:

45 (a) The immediacy and extent to which the violation threatens the public health or safety;

1 (b) Any prior violations of statutes, rules or orders;
2 (c) The history of the person incurring a penalty in taking all feasible steps to correct any vio-
3 lation; and
4 (d) Any other aggravating or mitigating factors.
5 (5) Civil penalties under this section shall be imposed as provided in ORS 183.745.
6 (6) The moneys received by the office from civil penalties under this section shall be deposited
7 in the Health Licensing Office Account and are continuously appropriated to the office for the ad-
8 ministration and enforcement of the laws the office is charged with administering and enforcing that
9 govern the person against whom the penalty was imposed.
10 **SECTION 7.** Section 2, chapter 771, Oregon Laws 2013, as amended by section 9, chapter 674,
11 Oregon Laws 2015, and section 11, chapter 284, Oregon Laws 2019, is amended to read:
12 **Sec. 2.** (1) As used in this section and section 3a, chapter 771, Oregon Laws 2013:
13 (a)(A) "Applied behavior analysis" means the design, implementation and evaluation of environ-
14 mental modifications, using behavioral stimuli and consequences, to produce significant improvement
15 in human social behavior, including the use of direct observation, measurement and functional
16 analysis of the relationship between environment and behavior, that is provided by:
17 (i) A licensed health care professional as defined in ORS 676.802;
18 (ii) A behavior analyst or assistant behavior analyst licensed under ORS 676.810; or
19 (iii) A behavior analysis interventionist [*registered*] **licensed** under ORS 676.815 who receives
20 ongoing training and supervision by a licensed behavior analyst, by a licensed assistant behavior
21 analyst or by a licensed health care professional.
22 (B) "Applied behavior analysis" does not mean psychological testing, neuropsychology,
23 psychotherapy, cognitive therapy, sex therapy, psychoanalysis, hypnotherapy and long-term coun-
24 seling as treatment modalities.
25 (b) "Autism spectrum disorder" has the meaning given that term in the fifth edition of the Di-
26 agnostic and Statistical Manual of Mental Disorders (DSM-5) published by the American Psychiatric
27 Association.
28 (c) "Diagnosis" means medically necessary assessment, evaluation or testing.
29 (d) "Health benefit plan" has the meaning given that term in ORS 743B.005.
30 (e) "Medically necessary" means in accordance with the definition of medical necessity that is
31 specified in the policy or certificate for the health benefit plan and that applies to all covered ser-
32 vices under the plan.
33 (f) "Treatment for autism spectrum disorder" includes applied behavior analysis for up to 25
34 hours per week and any other mental health or medical services identified in the individualized
35 treatment plan, as described in subsection (6) of this section.
36 (2) A health benefit plan shall provide coverage of:
37 (a) The screening for and diagnosis of autism spectrum disorder by a licensed neurologist,
38 pediatric neurologist, developmental pediatrician, psychiatrist or psychologist, who has experience
39 or training in the diagnosis of autism spectrum disorder; and
40 (b) Medically necessary treatment for autism spectrum disorder and the management of care, for
41 an individual who begins treatment before nine years of age, subject to the requirements of this
42 section.
43 (3) This section does not require coverage for:
44 (a) Services provided by a family or household member;
45 (b) Services that are custodial in nature or that constitute marital, family, educational or

training services;

(c) Custodial or respite care, equine assisted therapy, creative arts therapy, wilderness or adventure camps, social counseling, telemedicine, music therapy, neurofeedback, chelation or hyperbaric chambers;

(d) Services provided under an individual education plan in accordance with the Individuals with Disabilities Education Act, 20 U.S.C. 1400 et seq.;

(e) Services provided through community or social programs; or

(f) Services provided by the Department of Human Services or the Oregon Health Authority, other than employee benefit plans offered by the department and the authority.

(4) An insurer may not terminate coverage or refuse to issue or renew coverage for an individual solely because the individual has received a diagnosis of autism spectrum disorder or has received treatment for autism spectrum disorder.

(5) Coverage under this section may be subject to utilization controls that are reasonable in the context of individual determinations of medical necessity. An insurer may require:

(a) An autism spectrum disorder diagnosis by a professional described in subsection (2)(a) of this section if the original diagnosis was not made by a professional described in subsection (2)(a) of this section.

(b) Prior authorization for coverage of a maximum of 25 hours per week of applied behavior analysis recommended in an individualized treatment plan approved by a professional described in subsection (2)(a) of this section for an individual with autism spectrum disorder, as long as the insurer makes a prior authorization determination no later than 30 calendar days after receiving the request for prior authorization, notwithstanding ORS 743B.423.

(6) If an individual is receiving applied behavior analysis, an insurer may require submission of an individualized treatment plan, which shall include all elements necessary for the insurer to appropriately determine coverage under the health benefit plan. The individualized treatment plan must be based on evidence-based screening criteria. An insurer may require an updated individualized treatment plan, not more than once every six months, that includes observed progress as of the date the updated plan was prepared, for the purpose of performing utilization review and medical management. The insurer may require the individualized treatment plan to be approved by a professional described in subsection (2)(a) of this section, and to include the:

(a) Diagnosis;

(b) Proposed treatment by type;

(c) Frequency and anticipated duration of treatment;

(d) Anticipated outcomes stated as goals, including specific cognitive, social, communicative, self-care and behavioral goals that are clearly stated, directly observed and continually measured and that address the characteristics of the autism spectrum disorder; and

(e) Signature of the treating provider.

(7)(a) Once coverage for applied behavior analysis has been approved, the coverage continues as long as:

(A) The individual continues to make progress toward the majority of the goals of the individualized treatment plan; and

(B) Applied behavior analysis is medically necessary.

(b) An insurer may require periodic review of an individualized treatment plan, as described in subsection (6) of this section, and modification of the individualized treatment plan if the review shows that the individual receiving the treatment is not making substantial clinical progress toward

1 the goals of the individualized treatment plan.
2 (8) Coverage under this section may be subject to requirements and limitations no more re-
3 strictive than those imposed on coverage or reimbursement of expenses arising from the treatment
4 of other medical conditions under the policy or certificate, including but not limited to:
5 (a) Requirements and limitations regarding in-network providers; and
6 (b) Provisions relating to deductibles, copayments and coinsurance.
7 (9) This section applies to coverage for up to 25 hours per week of applied behavior analysis for
8 an individual if the coverage is first requested when the individual is under nine years of age. This
9 section does not limit coverage for any services that are otherwise available to an individual under
10 ORS 743A.168 or 743A.190, including but not limited to:
11 (a) Treatment for autism spectrum disorder other than applied behavior analysis or the services
12 described in subsection (3) of this section;
13 (b) Applied behavior analysis for more than 25 hours per week; or
14 (c) Applied behavior analysis for an individual if the coverage is first requested when the indi-
15 vidual is nine years of age or older.
16 (10) Coverage under this section includes treatment for autism spectrum disorder provided in the
17 individual's home or a licensed health care facility or, for treatment provided by a licensed health
18 care professional as defined in ORS 676.802 or a behavior analyst or assistant behavior analyst li-
19 censed under ORS 676.810 **or a behavior analysis interventionist licensed under ORS 676.815**,
20 in a setting approved by the health care professional, behavior analyst or assistant behavior analyst.
21 (11) An insurer that provides coverage of applied behavior analysis in accordance with a deci-
22 sion of an independent review organization that was made prior to January 1, 2016, shall continue
23 to provide coverage, subject to modifications made in accordance with subsection (7) of this section.
24 (12) ORS 743A.001 does not apply to this section.
25 **SECTION 8.** Section 22, chapter 771, Oregon Laws 2013, is amended to read:
26 **Sec. 22.** Section 2 [*of this 2013 Act*]**, chapter 771, Oregon Laws 2013,** is repealed January 2,
27 [*2022*] **2030**.
28 **SECTION 9.** ORS 109.675 is amended to read:
29 109.675. (1) A minor 14 years of age or older may obtain, without parental knowledge or
30 consent[*,*]**:**
31 **(a)** Outpatient diagnosis or treatment of a mental or emotional disorder or a chemical depend-
32 ency, excluding methadone maintenance, by a physician or physician assistant licensed by the
33 Oregon Medical Board, a psychologist licensed by the Oregon Board of Psychology, a nurse practi-
34 tioner registered by the Oregon State Board of Nursing, a clinical social worker licensed by the
35 State Board of Licensed Social Workers, a professional counselor or marriage and family therapist
36 licensed by the Oregon Board of Licensed Professional Counselors and Therapists, a naturopathic
37 physician licensed by the Oregon Board of Naturopathic Medicine or a community mental health
38 program established and operated pursuant to ORS 430.620 when approved to do so by the Oregon
39 Health Authority pursuant to rule.
40 **(b) Outpatient treatment of a mental or emotional disorder or a chemical dependency,**
41 **excluding methadone maintenance, by a behavior analyst or assistant behavior analyst li-**
42 **censed by the Behavior Analysis Regulatory Board or a behavior analysis interventionist li-**
43 **censed by the Health Licensing Office if the treatment is within the scope of practice of the**
44 **behavior analyst, assistant behavior analyst or behavior analysis interventionist.**
45 (2) However, the person providing treatment shall have the parents of the minor involved before

the end of treatment unless the parents refuse or unless there are clear clinical indications to the contrary, which shall be documented in the treatment record. The provisions of this subsection do not apply to:

(a) A minor who has been sexually abused by a parent; or

(b) An emancipated minor, whether emancipated under the provisions of ORS 109.510 and 109.520 or 419B.550 to 419B.558 or, for the purpose of this section only, emancipated by virtue of having lived apart from the parents or legal guardian while being self-sustaining for a period of 90 days prior to obtaining treatment as provided by this section.

SECTION 10. ORS 419B.005 is amended to read:

419B.005. As used in ORS 419B.005 to 419B.050, unless the context requires otherwise:

(1)(a) "Abuse" means:

(A) Any assault, as defined in ORS chapter 163, of a child and any physical injury to a child which has been caused by other than accidental means, including any injury which appears to be at variance with the explanation given of the injury.

(B) Any mental injury to a child, which shall include only observable and substantial impairment of the child's mental or psychological ability to function caused by cruelty to the child, with due regard to the culture of the child.

(C) Rape of a child, which includes but is not limited to rape, sodomy, unlawful sexual penetration and incest, as those acts are described in ORS chapter 163.

(D) Sexual abuse, as described in ORS chapter 163.

(E) Sexual exploitation, including but not limited to:

(i) Contributing to the sexual delinquency of a minor, as defined in ORS chapter 163, and any other conduct which allows, employs, authorizes, permits, induces or encourages a child to engage in the performing for people to observe or the photographing, filming, tape recording or other exhibition which, in whole or in part, depicts sexual conduct or contact, as defined in ORS 167.002 or described in ORS 163.665 and 163.670, sexual abuse involving a child or rape of a child, but not including any conduct which is part of any investigation conducted pursuant to ORS 419B.020 or which is designed to serve educational or other legitimate purposes; and

(ii) Allowing, permitting, encouraging or hiring a child to engage in prostitution as described in ORS 167.007 or a commercial sex act as defined in ORS 163.266, to purchase sex with a minor as described in ORS 163.413 or to engage in commercial sexual solicitation as described in ORS 167.008.

(F) Negligent treatment or maltreatment of a child, including but not limited to the failure to provide adequate food, clothing, shelter or medical care that is likely to endanger the health or welfare of the child.

(G) Threatened harm to a child, which means subjecting a child to a substantial risk of harm to the child's health or welfare.

(H) Buying or selling a person under 18 years of age as described in ORS 163.537.

(I) Permitting a person under 18 years of age to enter or remain in or upon premises where methamphetamines are being manufactured.

(J) Unlawful exposure to a controlled substance, as defined in ORS 475.005, or to the unlawful manufacturing of a cannabinoid extract, as defined in ORS 475B.015, that subjects a child to a substantial risk of harm to the child's health or safety.

(b) "Abuse" does not include reasonable discipline unless the discipline results in one of the conditions described in paragraph (a) of this subsection.

(2) "Child" means an unmarried person who:

1 (a) Is under 18 years of age; or
2 (b) Is under 21 years of age and residing in or receiving care or services at a child-caring
3 agency as that term is defined in ORS 418.205.
4 (3) "Higher education institution" means:
5 (a) A community college as defined in ORS 341.005;
6 (b) A public university listed in ORS 352.002;
7 (c) The Oregon Health and Science University; and
8 (d) A private institution of higher education located in Oregon.
9 (4)(a) "Investigation" means a detailed inquiry into or assessment of the safety of a child alleged
10 to have experienced abuse.
11 (b) "Investigation" does not include screening activities conducted upon the receipt of a report.
12 (5) "Law enforcement agency" means:
13 (a) A city or municipal police department.
14 (b) A county sheriff's office.
15 (c) The Oregon State Police.
16 (d) A police department established by a university under ORS 352.121 or 353.125.
17 (e) A county juvenile department.
18 (6) "Public or private official" means:
19 (a) Physician or physician assistant licensed under ORS chapter 677 or naturopathic physician,
20 including any intern or resident.
21 (b) Dentist.
22 (c) School employee, including an employee of a higher education institution.
23 (d) Licensed practical nurse, registered nurse, nurse practitioner, nurse's aide, home health aide
24 or employee of an in-home health service.
25 (e) Employee of the Department of Human Services, Oregon Health Authority, Early Learning
26 Division, Department of Education, Youth Development Division, Office of Child Care, the Oregon
27 Youth Authority, a local health department, a community mental health program, a community de-
28 velopmental disabilities program, a county juvenile department, a child-caring agency as that term
29 is defined in ORS 418.205 or an alcohol and drug treatment program.
30 (f) Peace officer.
31 (g) Psychologist.
32 (h) Member of the clergy.
33 (i) Regulated social worker.
34 (j) Optometrist.
35 (k) Chiropractor.
36 (L) Certified provider of foster care, or an employee thereof.
37 (m) Attorney.
38 (n) Licensed professional counselor.
39 (o) Licensed marriage and family therapist.
40 (p) Firefighter or emergency medical services provider.
41 (q) A court appointed special advocate, as defined in ORS 419A.004.
42 (r) A child care provider registered or certified under ORS 329A.030 and 329A.250 to 329A.450.
43 (s) Member of the Legislative Assembly.
44 (t) Physical, speech or occupational therapist.
45 (u) Audiologist.

(v) Speech-language pathologist.

(w) Employee of the Teacher Standards and Practices Commission directly involved in investigations or discipline by the commission.

(x) Pharmacist.

(y) An operator of a preschool recorded program under ORS 329A.255.

(z) An operator of a school-age recorded program under ORS 329A.257.

(aa) Employee of a private agency or organization facilitating the provision of respite services, as defined in ORS 418.205, for parents pursuant to a properly executed power of attorney under ORS 109.056.

(bb) Employee of a public or private organization providing child-related services or activities:

(A) Including but not limited to youth groups or centers, scout groups or camps, summer or day camps, survival camps or groups, centers or camps that are operated under the guidance, supervision or auspices of religious, public or private educational systems or community service organizations; and

(B) Excluding community-based, nonprofit organizations whose primary purpose is to provide confidential, direct services to victims of domestic violence, sexual assault, stalking or human trafficking.

(cc) A coach, assistant coach or trainer of an amateur, semiprofessional or professional athlete, if compensated and if the athlete is a child.

(dd) Personal support worker, as defined in ORS 410.600.

(ee) Home care worker, as defined in ORS 410.600.

(ff) Animal control officer, as defined in ORS 609.500.

(gg) Member of a school district board or public charter school governing body.

(hh) An individual who is paid by a public body, in accordance with ORS 430.215, to provide a service identified in an individualized written service plan of a child with a developmental disability.

(ii) A behavior analyst or assistant behavior analyst licensed by the Behavior Analysis Regulatory Board or a behavior analysis interventionist licensed by the Health Licensing Office.

SECTION 11. ORS 675.850 is amended to read:

675.850. (1) A mental health care or social health professional may not practice conversion therapy if the recipient of the conversion therapy is under 18 years of age.

(2) As used in this section:

(a)(A) "Conversion therapy" means providing professional services for the purpose of attempting to change a person's sexual orientation or gender identity, including attempting to change behaviors or expressions of self or to reduce sexual or romantic attractions or feelings toward individuals of the same gender.

(B) "Conversion therapy" does not mean:

(i) Counseling that assists a client who is seeking to undergo a gender transition or who is in the process of undergoing a gender transition; or

(ii) Counseling that provides a client with acceptance, support and understanding, or counseling that facilitates a client's coping, social support and identity exploration or development, including counseling in the form of sexual orientation-neutral or gender identity-neutral interventions provided for the purpose of preventing or addressing unlawful conduct or unsafe sexual practices, as long as the counseling is not provided for the purpose of attempting to change the client's sexual orientation or gender identity.

1 (b)(A) "Mental health care or social health professional" means:
2 (i) A licensed psychologist as defined in ORS 675.010;
3 (ii) A psychologist associate licensed under ORS 675.065;
4 (iii) An occupational therapist or occupational therapy assistant both as defined in ORS 675.210;
5 (iv) A regulated social worker as defined in ORS 675.510;
6 (v) A licensed marriage and family therapist or licensed professional counselor both as defined
7 in ORS 675.705; [*and*]
8 (vi) An individual who provides counseling as part of an educational or training program nec-
9 essary to practice any of the professions described in sub-subparagraphs (i) to (v) of this
10 subparagraph[.]**; and**
11 **(vii) A behavior analyst or assistant behavior analyst licensed under ORS 676.810 or a**
12 **behavior analysis interventionist licensed under ORS 676.815.**
13 (B) "Mental health care or social health professional" includes any individual not described in
14 this paragraph who is licensed in this state and whose license authorizes the individual to provide
15 mental health care or social health counseling services.
16 (3) Any state board that regulates licensees described in subsection (2)(b)(B) of this section may
17 impose any form of discipline that the board may impose on a licensee under the laws of this state
18 for violating a law of this state or a rule adopted by the board.
19 **SECTION 12.** ORS 676.150 is amended to read:
20 676.150. (1) As used in this section:
21 (a) "Board" means the:
22 (A) State Board of Examiners for Speech-Language Pathology and Audiology;
23 (B) State Board of Chiropractic Examiners;
24 (C) State Board of Licensed Social Workers;
25 (D) Oregon Board of Licensed Professional Counselors and Therapists;
26 (E) Oregon Board of Dentistry;
27 (F) Board of Licensed Dietitians;
28 (G) State Board of Massage Therapists;
29 (H) Oregon Board of Naturopathic Medicine;
30 (I) Oregon State Board of Nursing;
31 (J) Long Term Care Administrators Board;
32 (K) Oregon Board of Optometry;
33 (L) State Board of Pharmacy;
34 (M) Oregon Medical Board;
35 (N) Occupational Therapy Licensing Board;
36 (O) Oregon Board of Physical Therapy;
37 (P) Oregon Board of Psychology;
38 (Q) Board of Medical Imaging;
39 (R) State Board of Direct Entry Midwifery;
40 (S) State Board of Denture Technology;
41 (T) Respiratory Therapist and Polysomnographic Technologist Licensing Board;
42 (U) Oregon Health Authority, to the extent that the authority licenses emergency medical ser-
43 vices providers;
44 (V) Oregon State Veterinary Medical Examining Board; [*or*]
45 (W) State Mortuary and Cemetery Board[.]**; or**

(X) Behavior Analysis Regulatory Board.

(b) "Licensee" means a health professional licensed or certified by or registered with a board.

(c) "Prohibited conduct" means conduct by a licensee that:

(A) Constitutes a criminal act against a patient or client; or

(B) Constitutes a criminal act that creates a risk of harm to a patient or client.

(d) "Unprofessional conduct" means conduct unbecoming a licensee or detrimental to the best interests of the public, including conduct contrary to recognized standards of ethics of the licensee's profession or conduct that endangers the health, safety or welfare of a patient or client.

(2) Unless state or federal laws relating to confidentiality or the protection of health information prohibit disclosure, a licensee who has reasonable cause to believe that another licensee has engaged in prohibited or unprofessional conduct shall report the conduct to the board responsible for the licensee who is believed to have engaged in the conduct. The reporting licensee shall report the conduct without undue delay, but in no event later than 10 working days after the reporting licensee learns of the conduct.

(3) A licensee who is convicted of a misdemeanor or felony or who is arrested for a felony crime shall report the conviction or arrest to the licensee's board within 10 days after the conviction or arrest.

(4) The board responsible for a licensee who is reported to have engaged in prohibited or unprofessional conduct shall investigate in accordance with the board's rules. If the board has reasonable cause to believe that the licensee has engaged in prohibited conduct, the board shall present the facts to an appropriate law enforcement agency without undue delay, but in no event later than 10 working days after the board finds reasonable cause to believe that the licensee engaged in prohibited conduct.

(5) A licensee who fails to report prohibited or unprofessional conduct as required by subsection (2) of this section or the licensee's conviction or arrest as required by subsection (3) of this section is subject to discipline by the board responsible for the licensee.

(6) A licensee who fails to report prohibited conduct as required by subsection (2) of this section commits a Class A violation.

(7)(a) Notwithstanding any other provision of law, a report under subsection (2) or (3) of this section is confidential under ORS 676.175.

(b) A board may disclose a report as provided in ORS 676.177.

(c) If the Health Licensing Office receives a report described in this subsection, the report is confidential and the office may only disclose the report pursuant to ORS 676.595 and 676.599.

(8) Except as part of an application for a license or for renewal of a license and except as provided in subsection (3) of this section, a board may not require a licensee to report the licensee's criminal conduct.

(9) The obligations imposed by this section are in addition to and not in lieu of other obligations to report unprofessional conduct as provided by statute.

(10) A licensee who reports to a board in good faith as required by subsection (2) of this section is immune from civil liability for making the report.

(11) A board and the members, employees and contractors of the board are immune from civil liability for actions taken in good faith as a result of a report received under subsection (2) or (3) of this section.

SECTION 13. (1) The amendments to ORS 109.675, 419B.005, 675.850, 676.150, 676.815, 676.820, 676.825, 676.830 and 676.992 and sections 2 and 22, chapter 771, Oregon Laws 2013, by

1 **sections 2 to 12 of this 2021 Act become operative on January 1, 2022.**
2 **(2) The Behavior Analysis Regulatory Board and the Health Licensing Office may take**
3 **any action before the operative date specified in subsection (1) of this section that is neces-**
4 **sary for the board and the office to exercise, on and after the operative date specified in**
5 **subsection (1) of this section, all of the duties, functions and powers conferred on the board**
6 **and the office by the amendments 109.675, 419B.005, 675.850, 676.150, 676.815, 676.820, 676.825,**
7 **676.830 and 676.992 and sections 2 and 22, chapter 771, Oregon Laws 2013, by sections 2 to 12**
8 **of this 2021 Act.**
9 **SECTION 14.** **This 2021 Act takes effect on the 91st day after the date on which the 2021**
10 **regular session of the Eighty-first Legislative Assembly adjourns sine die.**
11

January 21, 2020

Paul Terdal
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paul@terdal.org

Behavior Analysis Regulatory Board
Oregon Health Authority
1430 Tandem Ave, NE, Suite 180
Salem, OR 97301-2192
By e-mail: maria.s.gutierrez@state.or.us

Re: Public Comment for January 22, 2021 Behavior Analysis Regulatory Board Meeting –Legislation for 2021 (SB355 and SB358)

Dear Chair Johns and Members of the Board,

I'm writing to provide testimony for the BARB meeting on January 22nd regarding Legislation for 2021.

In the July meeting, I submitted public comment about potential legislative concepts for this session. Two bills (SB355 and SB358) have been filed, based on those discussions:

- **SB355** delays the sunset of Oregon's Autism Health Insurance Reform law – which is currently set to expire at the end of this year. This law mandates coverage of medically necessary care for autism, including ABA.
- **SB358** fixes a number of gaps and technical issues with regulation of Behavior Analysts, such as requiring them to report child abuse; unprofessional conduct and criminal convictions; and provides enforcement authority and penalties for falsely claiming to be a licensed behavior analyst.

The bills were both filed on my behalf by the Senate Health Care committee.

SB355: Delaying Sunset of Oregon's Autism Health Insurance Reform law

In 2013, Oregon's legislature passed SB365, which clarified health insurance coverage requirements for autism therapies. Today, about 1,800 living wage jobs have been created under this statute to provide critical health services to thousands of Oregonians with autism.

SB365 sunsets on January 2, 2022 – meaning that it will be automatically repealed on that date unless the legislature takes action.

SB365 will ultimately need an extensive overhaul, to align it with the Federal Mental Health Parity and Addiction Equity Act (MHPAEA) and Affordable Care Act. For instance, SB365 allows age and visit limits that the Oregon Department of Justice and Insurance Commissioner have determined would violate MHPAEA. SB355 simply postpones the sunset by 8 years to January 2, 2030, to give more time to work through longer term issues. In the interim, coverage for treatment of autism is guided by two bulletins from Oregon's Insurance Commissioner that reconcile the conflicts with Federal law.

SB358: Refining Licensure of Behavior Analysts

The Behavior Analysis Regulatory Board (BARB) was created within the Oregon Health Licensing Office in 2013 as part of SB365 to license and regulate the practice of Applied Behavior Analysis (ABA) by Licensed Behavior Analysts (e.g., BCBAs), Licensed Assistant Behavior Analysts (e.g., BCaBA), and Registered Behavior Analysis Interventionists (analogous to the RBT). Since SB365 was enacted in 2013, the field of ABA has grown exponentially in Oregon, from a few dozen practitioners in 2013 to about 1,800 actively licensed or registered today.

While the licensing statutes and rules have been refined over the years, there remain numerous "glitches" or inconsistencies between how Oregon regulates Behavior Analysts relative to other behavioral health professionals. The goal of SB358 is to improve consumer protection by cleaning up these glitches and make regulation of behavior analysts more consistent with peer professions.

This bill addresses the following issues:

- Child abuse reporting: behavior analysts aren't on the list of professionals that must report child abuse (see https://www.oregonlaws.org/ors/419B.005)
- Prohibition on the practice of gay conversion therapy: Oregon prohibits gay conversion therapy by psychologists, occupational therapists, and other professionals but not specifically by behavior analysts (see https://www.oregonlaws.org/ors/675.850)
- Duty to report unprofessional conduct, arrests, and convictions: Oregon requires all other health professionals to report prohibited or unprofessional conduct by other licensees or their own criminal convictions, but this doesn't apply to behavior analysts (see https://www.oregonlaws.org/ors/676.150)
- Right to behavioral health treatment without parental consent: Oregon allows youth as young as 14 to seek treatment without parent consent from essentially any other type of behavioral health provider -- but not from a behavior analyst.
  - Currently, a 14 year old child could seek ABA therapy without parental consent from a psychologist, LPC, LCSW or other mental health professional, but not from a licensed behavior analyst (see https://www.oregonlaws.org/ors/109.675).
  - The practical effect is to allow (but not require) a stronger patient -provider relationship for teens, such as enabling them to sign approval for their own behavior change program
- Changing title of "*Registered* Behavior Analysis Interventionist" to "*Licensed* Behavior Analysis Interventionist": The use of the word "Registered" in the title is confusing and inconsistent with other state and federal laws that call for "Licensed" or "Certified" professionals.
  - "Registered" Behavior Analysis Interventionists are effectively "licensed" under ORS 676.815 and 676.820 to provide ABA therapy under supervision, but there are potentially significant issues:
    - Oregon has requested a Medicaid State Plan Amendment that would allow schools to be reimbursed by Medicaid for ABA as a school-based health service provided by "Licensed heath care professionals." Changing the name of the title for interventionists will help clarify that schools can be reimbursed by Medicaid for their services.

      - Other statutes, such as Mental Health Parity (ORS 743A.168) refer to professionals who are "licensed" or "certified" but make no reference to "registered."
  - It was Sen. Bates intent to change the title from "Registered" to "Licensed" in 2015, but his request doesn't appear to have been submitted to legislative counsel in drafting of that year's revisions to ABA licensing laws (SB696).
  - This changes the name of the title only – it does not change any other requirements for interventionists, and doesn't require any action by existing interventionists.
- Clarify and refine the Health Licensing Office's enforcement authority, which currently has numerous small quirks and gaps.
  - As one example, it is unlawful under ORS 676.820 to use the title of "Licensed Behavior Analyst" if it hasn't been officially granted – but there is no penalty for doing so and HLO doesn't have specific enforcement authority.
- Require the Health Licensing Office to consult with the BARB regarding enforcement actions
  - Currently, the BARB's only statutory role is in adopting administrative rules on licensing and the practice of ABA – the board itself has no role whatsoever in enforcement.
  - All enforcement authority resides with the staff of the Health Licensing Office. As a matter of practice, the HLO staff consults with the BARB before taking action, but nothing in the statute requires or even encourages this.
  - SB358 will specifically require the HLO staff to consult with the BARB on enforcement issues.

As drafted, SB358 also includes the same provision delaying the sunset date of SB365 as SB355, so if SB358 passes then SB355 would be redundant.

My hope is that all of these fixes will be straightforward and non-controversial. If there are any issues or concerns, I would love to hear them. If any provisions prove more complex or controversial than anticipated, it may be necessary to remove them and reconsider them in a future session.

Open issues in SB355 and SB358 to be fixed by amendment during the legislative session:

Both bills have some minor drafting issues that will need to be fixed by amendment.

SB355 – Issues to be Fixed by Amendment:

SB355 correctly delays the primary sunset provision in Section 22, Chapter 771 Oregon Laws 2013 to the year 2030.

However, the bill missed another important sunset provision in Section 24, Chapter 771 Oregon Laws 2013:

> **Sec. 24.** The amendments to [*section 3 of this 2013 Act by section 19 of this 2013 Act and the amendments to*] ORS 743A.190 and 750.055 by sections 20 and 21**, chapter 771, Oregon Laws 2013,** [*of this 2013 Act*] become operative January 2, 2022.

(Note: this provision was amended by SB696 (2015), codified as chapter 674 Oregon Laws 2015. The text quoted above is from that 2015 chapter).

It is particularly important to delay the sunset for 750.055, which defines coverage requirements for health care service contractors. Nearly all commercial insurance in Oregon is provided by health care service contractors, so this provision is critical. Because of the complexity of ORS 750.055, which has been amended several times since SB365(2013) was enacted, I would ask Legislative Counsel to review this and determine the best course of action.

<u>SB358 – Issues to be Fixed by Amendment</u>:

<u>Scope of the Health Licensing Office's enforcement authority:</u>

There are two provisions regarding the scope of the Health Licensing Office's enforcement authority that should be reviewed and aligned.

Page 2, line 24:

> [vio-]"lation of a rule adopted under ORS 676.810 or [*676.815*] **676.820**."

While this correctly extends the scope of enforcement to cover ORS 676.820, it inadvertently removes ORS 676.815 from the scope of enforcement. The "or" should be change to "to" as follows:

Page 2, line 24:

> [vio-]"lation of a rule adopted under ORS 676.810 **to** [or *676.815*] **676.820**."

Note that page 3, lines 23-24 similarly expand the scope of the Health Licensing Office's authority over these provisions, and reads:

Page 3, lines 23-24:

> (m) ORS [*676.810 and 676.815*] **676.802 to 676.830** (applied behavior analy-
>
> sis);

This expansion goes to a broader scope (676.802 to 676.830) instead of just 676.810 to 676.820. This broader scope is appropriate. I would ask Legislative Counsel to review these two provisions and see if there is a need to align them.

<u>Delay of Sunset Provision:</u>

Section 8 of SB358 contains the same sunset provision as SB355.

As with SB355, we also need to delay the sunset provision of Section 24, Chapter 771 Oregon Laws 2013 to ensure ongoing applicability to health care service contractors. See notes on SB355 above for details.

Future Legislation – Practice Act

Neither SB355 nor SB358 address enforcement issues involving the unlicensed practice of ABA.

- As discussed in previous BARB meetings, it is already unlawful in Oregon to provide any sort of medical or mental health treatment without a license, but the BARB / OHA doesn't have authority over the unlicensed practice of ABA to treat a mental health condition – that authority rests with other boards, including the Board of Psychology and Board of Medicine.

  - The Board of Psychology would prefer to transition this authority to the BARB.
- It would be very helpful for the BARB to work with the Board of Psychology on a letter or bulletin reminding interested parties that it is unlawful in Oregon to provide therapy services (including ABA) for the purpose of treating behavioral, emotional or mental disorders (including autism) without a license

Sincerely,

Paul Terdal

(503)984-2950

Attachments:

- Text of SB355 (See: https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB355)
- Text of SB358 (See: https://olis.oregonlegislature.gov/liz/2021R1/Measures/Overview/SB358)

Senate Bill 710

Sponsored by Senators GELSER, MANNING JR

SUMMARY

The following summary is not prepared by the sponsors of the measure and is not a part of the body thereof subject to consideration by the Legislative Assembly. It is an editor's brief statement of the essential features of the measure **as introduced.**

Modifies allowed and prohibited uses of restraint of children in care by child-caring agencies, proctor foster homes and developmental disabilities residential facilities. Prescribes reporting requirements following administration of restraint or involuntary seclusion. Directs Department of Human Services to adopt rules for individuals to be certified in administration of restraints and involuntary seclusion.

Modifies definition of "child caring agency" and "developmental disabilities residential facility."

Declares emergency, effective on passage.

1 **A BILL FOR AN ACT**

2 Relating to children in care; creating new provisions; amending ORS 418.205, 418.257, 418.259 and
3 419B.354; and declaring an emergency.

4 **Be It Enacted by the People of the State of Oregon:**

5 **SECTION 1. Definitions. As used in sections 1 to 7 of this 2021 Act:**

6 **(1) "Chemical restraint" means a drug or medication that is administered to a child in**
7 **care to control behavior or restrict freedom of movement.**

8 **(2) "Mechanical restraint" means a device used to restrict the movement of a child in**
9 **care or the movement or normal function of a portion of the body of a child in care.**

10 **(3) "Program" means:**

11 **(a) A child-caring agency or proctor foster home subject to ORS 418.205 to 418.327,**
12 **418.470, 418.475 or 418.950 to 418.970;**

13 **(b) A certified foster home; or**

14 **(c) A developmental disabilities residential facility.**

15 **(4) "Prone restraint" means a restraint in which a child in care is held face down on the**
16 **floor.**

17 **(5) "Reportable injury" means any type of injury to a child in care, including but not**
18 **limited to rug burns, fractures, sprains, bruising, pain, soft tissue injury, punctures,**
19 **scratches, concussions, abrasions, dizziness, loss of consciousness, loss of vision, visual dis-**
20 **turbance or death.**

21 **(6) "Restraint" means the restriction of a child in care's actions or movements by hold-**
22 **ing the child in care or using pressure or other means.**

23 **(7) "Serious bodily injury" means any significant impairment of the physical condition**
24 **of an individual, as determined by qualified medical personnel, whether self-inflicted or in-**
25 **flicted by someone else.**

26 **(8) "Supine restraint" means a restraint in which a child in care is held face up on the**
27 **floor.**

28 **SECTION 2. Prohibitions on restraints and involuntary seclusion. (1) Restraint or invol-**

NOTE: Matter in **boldfaced** type in an amended section is new; matter [*italic and bracketed*] is existing law to be omitted. New sections are in **boldfaced** type.

1 **untary seclusion may not be administered to a child in care for discipline, punishment or**
2 **retaliation or for the convenience of personnel, contractors or volunteers of a program.**
3 **(2) Except as provided in section 3 (3), (4) or (5) of this 2021 Act, the use of the following**
4 **types of restraint of a child in care are prohibited:**
5 **(a) Chemical restraint.**
6 **(b) Mechanical restraint.**
7 **(c) Prone restraint.**
8 **(d) Supine restraint.**
9 **(e) Any restraint that includes the nonincidental use of a solid object, including the**
10 **ground, a wall or the floor, to impede a child in care's movement.**
11 **(f) Any restraint that places, or creates a risk of placing, pressure on a child in care's**
12 **neck or throat.**
13 **(g) Any restraint that places, or creates a risk of placing, pressure on a child in care's**
14 **mouth.**
15 **(h) Any restraint that impedes, or creates a risk of impeding, a child in care's breathing.**
16 **(i) Any restraint that involves the intentional placement of hands, feet, elbows, knees or**
17 **any object on a child in care's neck, throat, genitals or other intimate parts.**
18 **(j) Any restraint that causes pressure to be placed, or creates a risk of causing pressure**
19 **to be placed, on a child in care's stomach or back by a knee, foot or elbow.**
20 **(k) Any other restraint, the primary purpose of which is to inflict pain.**
21 **SECTION 3.** **Permissible use of restraints or involuntary seclusion.** **(1) Restraint or in-**
22 **voluntary seclusion may be used on a child in care only if the child in care's behavior poses**
23 **a reasonable risk of imminent serious bodily injury to the child in care or others and less**
24 **restrictive interventions would not effectively reduce that risk.**
25 **(2) Notwithstanding subsection (1) of this section, the following types of restraint may**
26 **be used on a child in care:**
27 **(a) Holding a child in care's hand or arm to escort the child in care safely and without**
28 **the use of force from one area to another;**
29 **(b) Assisting a child in care to complete a task if the child in care does not resist the**
30 **physical contact; or**
31 **(c) Administering the minimal exertion of force necessary if the intervention does not**
32 **include a restraint described in section 2 (2) of this 2021 Act and the intervention is neces-**
33 **sary to break up a physical fight or effectively protect oneself or another from an assault,**
34 **serious bodily injury or sexual contact with the minimum physical contact necessary for**
35 **protection.**
36 **(3) Notwithstanding section 2 (2) of this 2021 Act, a mechanical restraint may be used**
37 **on a child in care if the mechanical restraint is:**
38 **(a) A protective or stabilizing device ordered by a licensed physician;**
39 **(b) A vehicle safety restraint when used as intended during the transport of a child in**
40 **care in a moving vehicle; or**
41 **(c) A treatment activity that is consistent with the child in care's treatment plan if the**
42 **treatment plan has been signed by the child in care's attending physician.**
43 **(4) Notwithstanding section 2 (2) of this 2021 Act, a chemical restraint may be adminis-**
44 **tered to a child in care if it is prescribed by a licensed physician or other qualified health**
45 **care professional acting under the professional's scope of practice for standard treatment**

1 **of the child in care's medical or psychiatric condition and the chemical restraint is admin-**
2 **istered as prescribed by a licensed physician or other qualified health care professional acting**
3 **within the professional's scope of practice.**
4 **(5) Notwithstanding section 2 (2) of this 2021 Act:**
5 **(a) The restraint described in section 2 (2)(e) of this 2021 Act may be used if the restraint**
6 **is necessary to gain control of a weapon.**
7 **(b) The restraint described in section 2 (2)(g) of this 2021 Act may be used if the restraint**
8 **is necessary for the purpose of extracting a body part from a bite.**
9 **(c) The restraints described in section 2 (2)(d) and (e) of this 2021 Act may be used by a**
10 **program providing state hospital-level care services to the child in care only if the following**
11 **requirements are met:**
12 **(A) The restraint is administered under the current written order of a physician;**
13 **(B) The physician's order is written specifically for the current situation;**
14 **(C) The restraint is used only as long as needed to prevent life-threatening injury and**
15 **while no other intervention or form of restraint is possible;**
16 **(D) The use of the restraint is continuously monitored by a physician or a qualified**
17 **mental health professional, the physician or qualified mental health professional is certified**
18 **in the administration of the type of restraint used and the physician or qualified mental**
19 **health professional continuously monitors the physical and psychological well-being of the**
20 **child in care at all times while the restraint is being used;**
21 **(E) Each individual administering the restraint is certified as described in section 6 of**
22 **this 2021 Act to administer the type of restraint used and the certification is current;**
23 **(F) One or more individuals with current cardiopulmonary resuscitation training are**
24 **present at all times while the restraint is being administered;**
25 **(G) No individual performing the restraint has a body mass index greater than 34;**
26 **(H) The program has written policies that require a physician or other licensed practi-**
27 **tioner to evaluate and document the physical, psychological and emotional well-being of the**
28 **child in care immediately following the use of the restraint; and**
29 **(I) The program is in compliance with any other requirements under sections 1 to 7 of**
30 **this 2021 Act, any applicable contract requirements and any other state or federal law related**
31 **to the use of restraints.**
32 **(6) If restraint or involuntary seclusion is used other than as provided in subsections (2)**
33 **to (4) of this section, the restraint or involuntary seclusion must be:**
34 **(a) Used only for as long as the child in care's behavior poses a reasonable risk of im-**
35 **minent serious bodily injury;**
36 **(b) Administered by personnel of the program who are currently certified as described**
37 **in section 6 of this 2021 Act to use that type of restraint or involuntary seclusion;**
38 **(c) Continuously monitored by personnel of the program at all times while the restraint**
39 **or involuntary seclusion is being used; and**
40 **(d) Performed in a manner that is safe, proportionate and appropriate to the child in**
41 **care's chronological and developmental age, size, gender identity, physical, medical and psy-**
42 **chiatric condition and any personal history, including history of physical or sexual abuse.**
43 **(7) In addition to the requirements described in subsection (6) of this section, if the re-**
44 **straint or involuntary seclusion continues for more than 10 minutes:**
45 **(a) The child in care must be provided with adequate access to the bathroom and water**

at least every 30 minutes; and

(b) Every five minutes after the first 10 minutes of the restraint or involuntary seclusion, an administrator for the program who is currently certified as described in section 6 of this 2021 Act to administer that type of restraint or involuntary seclusion must provide written authorization for the continuation of the restraint or involuntary seclusion. The written authorization must document why the restraint or involuntary seclusion continues to be the least restrictive intervention to reduce the risk of imminent serious bodily injury in the given circumstances.

SECTION 4. Notices and reports required following use of restraints or involuntary seclusion. (1) A program must establish procedures for the program to follow relating to the administration of restraints or involuntary seclusion consistent with the provisions of sections 2 and 3 of this 2021 Act and relating to the notices and reports required under this section following the use of restraints or involuntary seclusion of a child in care.

(2) A program must maintain a record of each incident in which a reportable injury arises from the use of a restraint or involuntary seclusion. The record under this subsection must include any audio or video recording immediately preceding, during and following the incident.

(3) A program that administers a restraint or involuntary seclusion of a child in care other than as provided in section 3 (2) to (4) of this 2021 Act must:

(a) Provide the following to the child in care's case managers, attorney, court appointed special advocate and parents or guardians:

(A) No later than 11:59 p.m. on the day the restraint or involuntary seclusion is administered, verbal or electronic notification that the restraint or involuntary seclusion occurred; and

(B) No later than 24 hours following the administration of the restraint or involuntary seclusion, written notification that includes:

(i) A description of the restraint or involuntary seclusion, the date of the restraint or involuntary seclusion, the times when the restraint or involuntary seclusion began and ended and the location of the restraint or involuntary seclusion.

(ii) A description of the child in care's activity that prompted the use of restraint or involuntary seclusion.

(iii) The efforts used to de-escalate the situation and the alternatives to restraint or involuntary seclusion that were attempted.

(iv) The names of each of individual who administered, monitored or approved the restraint or involuntary seclusion.

(v) For each individual who administered, monitored or approved the restraint or involuntary seclusion, whether the individual was currently certified under section 6 of this 2021 Act to administer the kind of restraint or involuntary seclusion and, if so, the date of the most recent certification and a description of the kinds of restraint the individual is certified to administer or, if the individual was not currently certified, the information required under paragraph (b) of this subsection.

(b) If an individual who administered, monitored or approved the restraint or involuntary seclusion was not currently certified in the administration of the type of restraint used or involuntary seclusion, written notice to the Department of Human Services and the child in care's attorney, court appointed special advocate and parents or guardians describing the

certification deficiency and the reason the restraint or involuntary seclusion was administered, monitored or approved by an individual without the proper certification.

(c) Hold a debriefing meeting with each individual who was involved in the incident and any other appropriate program personnel no later than two business days following the date of the restraint or involuntary seclusion, take written notes of the debriefing meeting and provide copies of the written notes to the child in care's attorney, case managers, court appointed special advocate and parents or guardians.

(d) If the child in care suffers a reportable injury arising from the restraint or involuntary seclusion, immediately provide written notification of the incident to the Department of Human Services and release all records related to the restraint or involuntary seclusion, including any photographs and audio or video recordings, to the department and the child's attorney, court appointed special advocate and parents or guardians.

(e) If serious bodily injury or the death of program personnel occurs in relation to the use of the restraint or involuntary seclusion, provide the department with written notification of the incident no later than 24 hours following the incident.

(4)(a) If a restraint or involuntary seclusion is used on a child in care more than two times in a seven-day period, the program shall immediately assemble a team to review the child in care's treatment plan.

(b) The team must include an administrator of the program, a representative of the Department of Human Services who is familiar with the child in care's case, a representative of the program's licensing agency, the child in care's attorney and court appointed special advocate and, if the child in care is 10 years of age or older and wants to participate, the child in care.

(c) The team shall prepare a written report identifying each of the team members and documenting the team's conclusions regarding the following:

(A) The suitability of the program for the child in care;

(B) Any necessary modifications to the child in care's treatment plan;

(C) What, if any, staff training regarding alternative therapeutic behavior management techniques are appropriate; and

(D) The impact of the restraints or involuntary seclusion on the child in care's physical, mental and emotional well-being.

(d) The program and any agency that was involved in placing the child in care in the program shall immediately implement any necessary corrective actions identified in the report.

SECTION 5. Reporting requirements. (1) A program must prepare and submit to the Department of Human Services a quarterly report detailing the use of restraint and involuntary seclusion for the preceding three-month period, including, at a minimum:

(a) The total number of incidents involving restraint.

(b) The total number of incidents involving involuntary seclusion.

(c) The total number of involuntary seclusions in a locked room.

(d) The total number of rooms available for use by the program for involuntary seclusion and a description of the dimensions and design of the rooms.

(e) The total number of children in care placed in restraint.

(f) The total number of children in care placed in involuntary seclusion.

(g) The total number of incidents under paragraph (a) or (b) of this subsection that re-

1 **sulted in reportable injuries.**
2 **(h) The number of children in care who were placed in restraint or involuntary seclusion**
3 **more than three times during the preceding three-month period and description of the steps**
4 **the program has taken to decrease the use of restraints and involuntary seclusion.**
5 **(i) The number of incidents in which individuals who administered restraints or involun-**
6 **tary seclusion were not certified as provided in section 6 of this 2021 Act to administer the**
7 **type of restraint used or involuntary seclusion.**
8 **(j) The demographic characteristics of all children in care to whom restraint or involun-**
9 **tary seclusion was administered, including race, ethnicity, gender, disability status, migrant**
10 **status, English proficiency and status as economically disadvantaged, unless the demo-**
11 **graphic information would reveal personally identifiable information about an individual child**
12 **in care.**
13 **(2)(a) The department shall make each quarterly report it receives under this section**
14 **available to the public on the department's website.**
15 **(b) Each program that submits a report under this section shall make its quarterly re-**
16 **port available to the public at the program's main office and on the program's website.**
17 **(c) Each program shall provide notice regarding how to access the quarterly reports to**
18 **the parents or guardians of children in care in the program. The program shall provide the**
19 **notice upon the child in care's admission and at least two times each year thereafter.**
20 **SECTION 6. Certification in use of restraints and seclusion. (1) The Department of Hu-**
21 **man Services shall adopt by rule standards for certification programs in restraint and in-**
22 **voluntary seclusion that:**
23 **(a) Teach evidence-based techniques that are shown to be effective in the prevention and**
24 **safe use of restraint or involuntary seclusion;**
25 **(b) Provide evidence-based skills training related to positive behavior support, conflict**
26 **prevention, de-escalation and crisis response techniques; and**
27 **(c) Are consistent with the philosophies, practices and techniques for restraint and in-**
28 **voluntary seclusion that are established by the department by rule or policy.**
29 **(2) The rules adopted under this section must:**
30 **(a) Require trainers to be certified and to have completed a minimum of 24 hours of ed-**
31 **ucation to train individuals in the appropriate use of restraints, involuntary seclusion and**
32 **alternative techniques, including de-escalation and nonviolent intervention;**
33 **(b) Require that participants in a certification program complete a minimum of 15 hours**
34 **of training;**
35 **(c) Emphasize the use of alternative techniques, including de-escalation and nonviolent**
36 **intervention;**
37 **(d) Require that training for the administration of restraints must be done in person;**
38 **(e) Require demonstration of written and technical proficiency prior to granting certi-**
39 **fication;**
40 **(f) Limit the duration of certification to two-years;**
41 **(g) Require that each certification include the dates during which the certification is**
42 **current, the types of physical restraints that the individual is certified to administer and the**
43 **name of the individual who conducted the training and administered the assessment of pro-**
44 **ficiency; and**
45 **(h) Require annual continuing education to maintain certification.**

1 **SECTION 7. Information provided to children in care. The Department of Human Ser-**
2 **vices shall provide each child in care with written information that:**
3 **(1) Explains the provisions of sections 1 to 7 of this 2021 Act;**
4 **(2) Provides instruction regarding how a child in care may report suspected inappropriate**
5 **use of restraint or involuntary seclusion;**
6 **(3) Assures the child in care that the child will not experience retaliation for reporting**
7 **suspected inappropriate uses of restraint or involuntary seclusion; and**
8 **(4) Includes the telephone number for the toll-free child abuse hotline described in ORS**
9 **417.805 and the telephone numbers and electronic mail addresses for the program's licensing**
10 **or certification agency, the child in care's caseworker and attorney, the child in care's court**
11 **appointed special advocate and Disability Rights Oregon.**
12 **SECTION 8.** ORS 418.205, as amended by sections 15a and 15b, chapter 19, Oregon Laws 2020
13 (first special session), is amended to read:
14 418.205. As used in ORS 418.205 to 418.327, 418.470, 418.475, 418.950 to 418.970 and 418.992 to
15 418.998, unless the context requires otherwise:
16 **(1) "Applied behavior analysis" has the meaning given that term in ORS 676.802.**
17 [*(1)*] **(2)** "Child" means an unmarried person under 21 years of age who resides in or receives
18 care or services from a child-caring agency.
19 [*(2)(a)*] **(3)(a)**"Child-caring agency":
20 (A) Means any private school, private agency, private organization or county program providing:
21 (i) Day treatment for children with emotional disturbances;
22 (ii) Adoption placement services;
23 (iii) Residential care, including but not limited to foster care or residential treatment for chil-
24 dren;
25 (iv) Residential care in combination with academic education and therapeutic care, including but
26 not limited to treatment for emotional, behavioral or mental health disturbances;
27 (v) Outdoor youth programs; [*or*]
28 **(vi) Center-based applied behavior analysis for children; or**
29 [*(vi)*] **(vii)** Other similar care or services for children.
30 (B) Includes the following:
31 (i) A shelter-care home that is not a foster home subject to ORS 418.625 to 418.645;
32 (ii) An independent residence facility as described in ORS 418.475;
33 (iii) A private residential boarding school; [*and*]
34 (iv) A child-caring facility as defined in ORS 418.950[*.*]**; and**
35 **(v) A private organization that provides transportation of or escort services for children**
36 **to or from a school, agency, organization or program described in this paragraph or to or**
37 **from any other treatment program, boarding school or outdoor wilderness program.**
38 (b) "Child-caring agency" does not include:
39 (A) Residential facilities or foster care homes certified or licensed by the Department of Human
40 Services under ORS 443.400 to 443.455, 443.830 and 443.835 for children receiving developmental
41 disability services;
42 (B) Any private agency or organization facilitating the provision of respite services for parents
43 pursuant to a properly executed power of attorney under ORS 109.056. For purposes of this subpar-
44 agraph, "respite services" means the voluntary assumption of short-term care and control of a minor
45 child without compensation or reimbursement of expenses for the purpose of providing a parent in

crisis with relief from the demands of ongoing care of the parent's child;

(C) A youth job development organization as defined in ORS 344.415;

(D) A shelter-care home that is a foster home subject to ORS 418.625 to 418.645;

(E) A foster home subject to ORS 418.625 to 418.645;

(F) A facility that exclusively serves individuals 18 years of age and older; or

(G) A facility that primarily serves both adults and children but requires that any child must be accompanied at all times by at least one custodial parent or guardian.

[*(3)*] **(4)** "Child-caring facility" has the meaning given that term in ORS 418.950.

[*(4)(a)*] **(5)(a)** "County program" means any county operated program that provides care or services to children in the custody of the Department of Human Services or the Oregon Youth Authority.

(b) "County program" does not include any local juvenile detention facility that receives state services provided and coordinated by the Department of Corrections under ORS 169.070.

[*(5)*] **(6)** "Governmental agency" means an executive, legislative or judicial agency, department, board, commission, authority, institution or instrumentality of this state or of a county, municipality or other political subdivision of this state.

[*(6)*] **(7)** "Independent residence facility" means a facility established or certified under ORS 418.475.

[*(7)(a)*] **(8)(a)** "Outdoor youth program" means a program that provides, in an outdoor living setting, services to children who have behavioral problems, mental health problems or problems with abuse of alcohol or drugs.

(b) "Outdoor youth program" does not include any program, facility or activity:

(A) Operated by a governmental entity;

(B) Operated or affiliated with the Oregon Youth Corps;

(C) Licensed by the Department of Human Services under other authority of the department; or

(D) Operated by a youth job development organization as defined in ORS 344.415.

[*(8)*] **(9)** "Private" means not owned, operated or administered by any governmental agency or unit.

[*(9)*] **(10)** "Private residential boarding school" means either of the following as the context requires:

(a) A child-caring agency that is a private school that provides residential care in combination with academic education and therapeutic care, including but not limited to treatment for emotional, behavioral or mental health disturbances; or

(b) A private school providing residential care that is primarily engaged in educational work under ORS 418.327.

[*(10)*] **(11)** "Proctor foster home" means a foster home certified by a child-caring agency under ORS 418.248 that is not subject to ORS 418.625 to 418.645.

[*(11)*] **(12)** "Provider of care or services for children" means a person, entity or organization that provides care or services to children, regardless of whether the child is in the custody of the Department of Human Services, and that does not otherwise meet the definition of, or requirements for, a child-caring agency. "Provider of care or services for children" includes a proctor foster home certified by a child-caring agency under ORS 418.248.

[*(12)*] **(13)** "Qualified residential treatment program" means a program described in section 12b, chapter 19, Oregon Laws 2020 (first special session) (Enrolled Senate Bill 1605).

[*(13)*] **(14)** "Shelter-care home" has the meaning given that term in ORS 418.470.

1 **SECTION 9.** ORS 418.257 is amended to read:
2 418.257. As used in ORS 418.257 to 418.259 **and sections 1 to 7 of this 2021 Act**:
3 (1) "Abuse" means one or more of the following:
4 (a) Any physical injury to a child in care caused by other than accidental means, or that appears
5 to be at variance with the explanation given of the injury.
6 (b) Neglect of a child in care.
7 (c) Abandonment, including desertion or willful forsaking of a child in care or the withdrawal
8 or neglect of duties and obligations owed a child in care by a child-caring agency, caretaker, certi-
9 fied foster home, developmental disabilities residential facility or other person.
10 (d) Willful infliction of physical pain or injury upon a child in care.
11 (e) An act that constitutes a crime under ORS 163.375, 163.405, 163.411, 163.415, 163.425, 163.427,
12 163.465, 163.467 or 163.525.
13 (f) Verbal abuse.
14 (g) Financial exploitation.
15 (h) Sexual abuse.
16 (i) Involuntary seclusion of a child in care for the convenience of a child-caring agency, care-
17 taker, certified foster home or developmental disabilities residential facility or to discipline the child
18 in care.
19 (j) [*A wrongful use of a physical or chemical restraint of a child in care, excluding an act of re-*
20 *straint prescribed by a physician licensed under ORS chapter 677 and any treatment activities that are*
21 *consistent with an approved treatment plan or in connection with a court order.*] **The use of restraint**
22 **or involuntary seclusion of a child in care in violation of section 2 or 3 of this 2021 Act.**
23 (2) "Certified foster home" means a foster home certified by the Department of Human Services
24 and subject to ORS 418.625 to 418.645.
25 (3)(a) "Child in care" means a person under 21 years of age who is residing in or receiving care
26 or services from:
27 (A) A child-caring agency or proctor foster home subject to ORS 418.205 to 418.327, 418.470,
28 418.475 or 418.950 to 418.970;
29 (B) A certified foster home; or
30 (C) A developmental disabilities residential facility.
31 (b) "Child in care" does not include a person under 21 years of age who is residing in any of
32 the entities listed in paragraph (a) of this subsection when the care provided is in the home of the
33 child by the child's parent.
34 [*(4) "Child-caring agency" has the meaning given that term in ORS 418.205.*]
35 [*(5)*] **(4)** "Developmental disabilities residential facility" means a residential facility or foster
36 home for children who are [*18*] **17** years of age or younger and receiving developmental disability
37 services that is subject to ORS 443.400 to 443.455, 443.830 and 443.835.
38 [*(6) "Involuntary seclusion" means the confinement of a child in care alone in a room from which*
39 *the child in care is physically prevented from leaving. "Involuntary seclusion" does not include age-*
40 *appropriate discipline, including but not limited to a time-out.*]
41 [*(7) "Proctor foster home" has the meaning given that term in ORS 418.205.*]
42 [*(8)(a)*] **(5)(a)** "Financial exploitation" means:
43 (A) Wrongfully taking the assets, funds or property belonging to or intended for the use of a
44 child in care.
45 (B) Alarming a child in care by conveying a threat to wrongfully take or appropriate moneys

or property of the child in care if the child would reasonably believe that the threat conveyed would be carried out.

(C) Misappropriating, misusing or transferring without authorization any moneys from any account held jointly or singly by a child in care.

(D) Failing to use the income or assets of a child in care effectively for the support and maintenance of the child in care.

(b) "Financial exploitation" does not include age-appropriate discipline that may involve the threat to withhold, or the withholding of, privileges.

[*(9)*] **(6)** "Intimidation" means compelling or deterring conduct by threat. "Intimidation" does not include age-appropriate discipline that may involve the threat to withhold privileges.

(7)(a) "Involuntary seclusion" means the confinement of a child in care alone in a room from which the child in care is physically prevented from leaving by any means.

(b) "Involuntary seclusion" does not include the removal of a child in care for a short period of time to provide the child in care with an opportunity to regain self-control if the child in care is in a setting from which the child in care is not physically prevented from leaving.

[*(10)*] **(8)** "Law enforcement agency" means:

(a) Any city or municipal police department.

(b) Any county sheriff's office.

(c) The Oregon State Police.

(d) Any district attorney.

(e) A police department established by a university under ORS 352.121 or 353.125.

[*(11)*] **(9)** "Neglect" means:

(a) Failure to provide the care, supervision or services necessary to maintain the physical and mental health of a child in care; or

(b) The failure of a child-caring agency, proctor foster home, certified foster home, developmental disabilities residential facility, caretaker or other person to make a reasonable effort to protect a child in care from abuse.

[*(12)*] **(10)** "Services" includes but is not limited to the provision of food, clothing, medicine, housing, medical services, assistance with bathing or personal hygiene or any other service essential to the well-being of a child in care.

[*(13)*] **(11)** "Sexual abuse" means:

(a) Sexual harassment, sexual exploitation or inappropriate exposure to sexually explicit material or language;

(b) Any sexual contact between a child in care and an employee of a child-caring agency, proctor foster home, certified foster home, developmental disabilities residential facility, caretaker or other person responsible for the provision of care or services to a child in care;

(c) Any sexual contact between a person and a child in care that is unlawful under ORS chapter 163 and not subject to a defense under that chapter; or

(d) Any sexual contact that is achieved through force, trickery, threat or coercion.

[*(14)*] **(12)** "Sexual contact" has the meaning given that term in ORS 163.305.

[*(15)*] **(13)** "Sexual exploitation" means sexual exploitation as described in ORS 419B.005 (1)(a)(E).

[*(16)*] **(14)** "Verbal abuse" means to threaten significant physical or emotional harm to a child in care through the use of:

(a) Derogatory or inappropriate names, insults, verbal assaults, profanity or ridicule; or

(b) Harassment, coercion, threats, intimidation, humiliation, mental cruelty or inappropriate sexual comments.

SECTION 10. ORS 418.259, as amended by section 9, chapter 19, Oregon Laws 2020 (first special session), is amended to read:

418.259. (1) The investigation conducted by the Department of Human Services under ORS 418.258 must result in one of the following findings:

(a) That the report is substantiated. A report is substantiated when there is reasonable cause to believe that the abuse of a child in care occurred.

(b) That the report is unsubstantiated. A report is unsubstantiated when there is no evidence that the abuse of a child in care occurred.

(c) That the report is inconclusive. A report is inconclusive when there is some indication that the abuse occurred but there is insufficient evidence to conclude that there is reasonable cause to believe that the abuse occurred.

(2) When a report is received under ORS 418.258 alleging that a child in care may have been subjected to abuse, the department shall notify the case managers for the child, the attorney for the child, the child's court appointed special advocate, the parents or guardians of the child, any attorney representing a parent or guardian of the child and any governmental agency that has a contract with the child-caring agency or developmental disabilities residential facility to provide care or services to the child that a report has been received.

(3)**(a)** The department [*may*] **shall** interview the child in care who is the subject of suspected abuse and **any** witnesses**, including other children,** without the presence of employees of the child-caring agency, proctor foster home or developmental disabilities residential facility, the provider of services at a certified foster home or department personnel. The department shall inform the child in care that the child may have the child's parent or guardian, if the child has not been committed to the custody of the department or the Oregon Youth Authority, or attorney present when participating in an interview conducted in the course of an abuse investigation.

(b) When investigating an allegation of inappropriate use of restraint or involuntary seclusion, the department shall:

(A) Conduct the interviews described in paragraph (a) of this subsection without the presence of employees of the child-caring agency, proctor foster home or developmental disabilities residential facility;

(B) Review all incident reports related to the child in care;

(C) Review any audio, video or photographic recordings of the restraint or involuntary seclusion, including the circumstances immediately before and following the incident;

(D) During an interview with the child in care who is the subject of the suspected abuse, ask the child about whether they experienced any reportable injury or pain as a result of the restraint; and

(E) Review the training records related to all of the staff who were involved in the use of restraint or involuntary seclusion.

(4) The department shall notify the following when a report of abuse is substantiated:

(a) The Director of Human Services.

(b) Personnel in the department responsible for the licensing, certificate or authorization of child-caring agencies.

(c) The department's lead personnel in that part of the department that is responsible for child

welfare generally.

(d) With respect to the child in care who is the subject of the abuse report and investigation, the case managers for the child, the attorney for the child, the child's court appointed special advocate, the parents or guardians of the child, any attorney representing a parent or guardian of the child and any governmental agency that has a contract with the child-caring agency to provide care or services to the child.

(e) The parents or guardians of the child in care who is the subject of the abuse report and investigation if the child in care has not been committed to the custody of the department or the youth authority. Notification under this paragraph may not include any details or information other than that a report of abuse has been substantiated.

(f) Any governmental agency that has a contract with the child-caring agency to provide care or services to a child in care.

(g) The local citizen review board established by the Judicial Department under ORS 419A.090.

(5) The department shall report on a quarterly basis to the interim legislative committees on child welfare for the purposes of public review and oversight of the quality and safety of child-caring agencies, certified foster homes and developmental disabilities residential facilities that are licensed, certified or authorized by the department in this state and of proctor foster homes that are certified by the child-caring agencies. Information provided in reports under this subsection may not contain the name or any identifying information of a child in care but must contain all of the following:

(a) The name of any child-caring agency, including an out-of-state child-caring agency, proctor foster home or developmental disabilities residential facility, or, provided there are five or more certified foster homes in the county, the name of the county where a certified foster home is located, where the department conducted an investigation pursuant to ORS 418.258 that resulted in a finding that the report of abuse was substantiated during that quarter;

(b) The approximate date that the abuse occurred;

(c) The nature of the abuse and a brief narrative description of the abuse that occurred;

(d) Whether physical injury, sexual abuse or death resulted from the abuse;

(e) Corrective actions taken or ordered by the department and the outcome of the corrective actions; and

(f) Information the department received in that quarter regarding any substantiated allegations of child abuse made by any other state involving a congregate care residential setting, as defined in ORS 419B.354, in which the department has placed Oregon children.

(6) The department's quarterly report under subsection (5) of this section must also contain all of the following:

(a) The total number of restraints used in programs that quarter;

(b) The total number of programs that reported the use of restraints of children in care that quarter;

(c) The total number of individual children in care who were subject to restraints that quarter;

(d) The number of reportable injuries to children in care that resulted from those restraints;

(e) The number of restraints applied by program staff who were not appropriately trained to implement the restraint; and

(f) The number of restraints that were reported for potential inappropriate use of restraint.

1 [*(6)*] **(7)** In compiling records, reports and other information during an investigation under ORS
2 418.258 (1) and in issuing findings, letters of concern or reprimands, the Director of Human Services
3 or the director's designee and the department may not refer to the employee, person or entity that
4 is the subject of the investigation as an "alleged perpetrator" but must refer to the employee, person
5 or entity as the "respondent."

6 **(8) As used in this section, "reportable injury," "restraint" and "program" have the**
7 **meanings given those terms in section 1 of this 2021 Act.**

8 **SECTION 11.** ORS 419B.354, as amended by sections 11a and 11b, chapter 19, Oregon Laws 2020
9 (first special session), is amended to read:

10 419B.354. (1) As used in this section:

11 (a) "Congregate care residential setting" means any setting that cares for more than one child
12 or ward and is not a setting described in ORS 418.205 [*(2)(b)(A), (D) or (E) or (10)*] **(3)(b)(A), (D)**
13 **or (E) or (11)**.

14 (b) "Sex trafficking" means the recruitment, harboring, transportation, provision, obtaining, pa-
15 tronizing or soliciting of a person under 18 years of age for the purpose of a commercial sex act,
16 as defined in ORS 163.266, or the recruitment, harboring, transportation, provision or obtaining of
17 a person over 18 years of age using force, fraud or coercion for the purpose of a commercial sex
18 act, as defined in ORS 163.266.

19 (2) The Department of Human Services may place a child or ward in a congregate care resi-
20 dential setting only if the setting is:

21 (a) A child-caring agency, as defined in ORS 418.205, a hospital, as defined in ORS 442.015, or
22 a rural hospital, as defined in ORS 442.470; and

23 (b) A qualified residential treatment program described in section 12b, chapter 19, Oregon Laws
24 2020 (first special session).

25 (3) Notwithstanding subsection (2) of this section, the department may place a child or ward in
26 a child-caring agency that is not a qualified residential treatment program if:

27 (a) The child-caring agency is providing prenatal, postpartum or parenting supports to the child
28 or ward.

29 (b) The child or ward is placed in an independent residence facility described in ORS 418.475
30 that is licensed by the department as a child-caring agency.

31 (c) The child or ward is, or is at risk of becoming, a victim of sex trafficking and the child-caring
32 agency is providing high-quality residential care and supportive services to the child or ward.

33 (d) The Oregon Health Authority has approved the placement as medically necessary and the
34 child-caring agency:

35 (A) Is a residential care facility;

36 (B) Is licensed by the authority and maintains site-specific accreditation from a nationally re-
37 cognized organization to provide psychiatric treatment to children; and

38 (C) Has an active provider agreement with the Oregon Medicaid program.

39 (e) The child-caring agency is an adolescent residential drug and alcohol treatment program li-
40 censed or certified by the State of Oregon to provide residential care, and the court has approved,
41 or approval is pending for, the placement in the child-caring agency of each child or ward over
42 whom the department retains jurisdiction.

43 (f) The placement with the child-caring agency is for the purpose of placing the child or ward
44 in a proctor foster home.

45 (g) The child-caring agency is a residential care facility licensed by the department that provides

1 short-term assessment and stabilization services.
2 (h) The child-caring agency is a shelter-care home, as defined in ORS 418.470, that provides
3 short-term assessment and stabilization services.
4 (i) The child-caring agency is a homeless, runaway or transitional living shelter licensed by the
5 department that provides short-term assessment and stabilization services.
6 (4) The department may not place a child or ward in a residential care facility or shelter-care
7 home described in subsection (3)(g) or (h) of this section:
8 (a) For more than 60 consecutive days or 90 cumulative days in a 12-month period; or
9 (b) If the residential care facility or shelter-care home also serves youth or youth offenders
10 served by the county juvenile department or youth offenders committed to the custody of the Oregon
11 Youth Authority by the court.
12 (5) The department may not place a child or ward in a homeless, runaway or transitional living
13 shelter described in subsection (3)(i) of this section for more than 60 consecutive or 90 cumulative
14 days in any 12-month period.
15 (6) Calculations of the number of days a child or ward is placed in a shelter-care home under
16 subsection (3)(h) of this section or a homeless, runaway or transitional living shelter under sub-
17 section (3)(i) of this section exclude the days the child or ward is in the shelter-care home or shelter
18 if the child or ward:
19 (a) Accessed the shelter-care home or shelter without the support or direction of the department;
20 and
21 (b) Is homeless or a runaway, as defined by the department by rule.
22 (7)(a) Nothing in this section prohibits the Oregon Youth Authority from placing a youth
23 offender committed to its custody in a placement that is not a qualified residential treatment pro-
24 gram.
25 (b) Nothing in this section prohibits the Oregon Youth Authority or a county juvenile depart-
26 ment from placing a youth offender or a youth served by the Oregon Youth Authority or the county
27 juvenile department in shelter care or detention under ORS chapter 419C.
28 **SECTION 12. Captions. The section captions used in this 2021 Act are provided only for**
29 **the convenience of the reader and do not become part of the statutory law of this state or**
30 **express any legislative intent in the enactment of this 2021 Act.**
31 **SECTION 13. Effective date. This 2021 Act being necessary for the immediate preserva-**
32 **tion of the public peace, health and safety, an emergency is declared to exist, and this 2021**
33 **Act takes effect on its passage.**
34

Public/Interested Parties' Feedback

Executive session

Pursuant to ORS 192.660(2)(f) and ORS 676.595 to consider information or records exempt from public inspection.

Items for Board Action

Other Board Business

Health Licensing Office
Behavior Analysis Regulatory Board
January 22, 2021

PLEASE PRINT

Name (First, Last) and Email	Representing	Request to Comment (yes/no)
Jenny Fischer	Cascade ABA/Cascade Behavioral Intervention, LLC	No
Michelle Sherbon	Western Psychological & Counseling Services, P.C.	N o
Paul Terdal		Yes
Michelle Heid	Advanced Behavioral Pathways	No