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BUREAU OF CHILDREN'S SERVICES

October 22, 2010

Shay Erhard
OMHSA
233 Beechmont Bldg.
DGS-Complex
PO Box 2675
Harrisburg, PA 17105-2675

Dear Mr. Erhard,

Below are my comments in reference to the proposed regulations for RTFs (Reg 14.522). I have limited my concerns to areas governing the use of restrictive procedures. This focus is related to my experience as President of a training company that has delivered restrictive procedure and behavior support/intervention training (Safe Crisis Management ®) to youth service agencies and schools in the Commonwealth for over thirty years. In addition, my experience includes residential care, university based training and participation in the state task force that developed the existing 3800 regulations.

Let me begin with the "Section II: Statement of Need". I can share two concerns here. First, there is a statement (12) that the proposed regulation is not mandated by any "Federal Regulation". This is true with regard to the existing 3800 text that is the bulk of the proposal; however, the additions and changes with regard to "Restrictive Procedures" are a duplicate of Federal HCFA (now CMS) rules on restraint and seclusion. These are Federal requirements for RTFs to access Medicare/Medicaid. They were initiated in 1999 and revised in 1997.

Perhaps this duplication is appropriate but it is misleading to state that there is "not" federal mandate involved.

Second, the area of increased costs associated with the increased requirements for training are suggested to be moot because a reduction in the length of stay will offset higher the per diems. While this may hold true for consumers, the operational cost for providers will be annually higher. I think the assumption regarding the increased cost of training staff and providing for physician oversight of the restrictive procedure process is sorely under estimated. I think the Department has responsibility to provide actual cost estimates in this area.

Proposed Regulations:

1. <u>Definitions</u>: I think confusion exists in the definition section when "Emergency Safety Interventions" are defined but "Restrictive Procedures" are not. It seems to me that "restrictive procedures" should be included in the "Emergency Safety Intervention" definition, e.g. "...ESI includes allowable restrictive procedures such as...".

   "Time-out" should also be added to the definition section. This strategy is very often misunderstood in the field.

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2. **Section 23.34** – Notification of Restraint Policy

   Subsection d. – I believe there is an omission in item d. "Provide a copy of the RTF Restraint..." – should probably read "Provide a copy of the RFT Restraint Policy".

   This section also specifies that the printed policy must be in a "language" that the child, family, guardian understand. Does this mean having this policy printed in various languages? If so, why not provide all program policies in all necessary translation? "Restraint Policy" is only one of many that parents should understand.

   Subsection e. – Here we are requiring contact information for the "disability rights network". Would this not be better placed in the section covering "Child Rights" (23.32-F) or 23.33 – "Deprivation of Rights"? It seems to me that parents and guardians have a right to know they can access the network for any violation of their rights not just those related to restraint.

3. **Section 25.52-Subsection b** – This section speaks to hiring staff. It requires a pre-employment physical. I suggest adding language that requires an assessment of the staff capacity to perform "emergency safety interventions". The competent and safe performance of "emergency interventions" during "emergency situations" require a physical capacity. Child and staff safety are at risk when staff who are physically unable to perform "emergency intervention" duty are hired for direct care positions.

   Since the regulations also require that the "Mental Health Professionals" position be trained in the emergency interventions (Section 23.250-G-3-8), it makes sense that a physical assessment take place for them also.

   A traditional physical examination performed by an M.D. will not measure the capacity to perform a physical restraint. However, it usually can serve to screen individuals who would be unable to perform.

4. **Section 23.62** – Annual Training (staff)

   Subsection C.-5 and d. – This subsection requires 40 hours of annual training for staff – 20 of those 40 hours are to be focused on 18 different topical areas. In addition, staff must (d.) have emergency intervention training with highly specified requirements (13). This (d) must be accomplished twice each year. It should be noted that there are no hour requirements for this semi-annual mandate suggested in the proposed regulations. While I fully support the establishment of substantial training requirements, the assumptions regarding fiscal impact of the requirements that are indicated in the document can only be described as naïve. This training will require more time than the regulations suggest making the fiscal implications substantial. While I realize that the regulations cannot state specific hours for these training topics, it is misleading not to recognize the substantial cost associated with these requirements.

5. **Section 23-201** – Restrictive Procedures

   I think the regulations would have more clarity were the section re-titled as "Emergency Interventions" and re-drafted with the sections that follow thru 23.206. Also, 23-201-b indicates that "restrictive procedures include "time-out, restraint and seclusion". 23-201-c indicates that "drug restraint" and "manual restraint" are the only restrictive procedures permitted in a RTF.

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"Time-out" is "left out". Of course, "Time-out" is not a restraint and it is not seclusion. Perhaps it does not qualify as a restrictive procedure.

23.201-f indicates that "a restrictive procedure may not result in harm or injury to a child". This is an uninformed statement. Any restrictive procedure, emergency intervention, can have an injury as an outcome. I am uncertain as to the purpose of the statement; however, it would create a regulatory violation for any accidental harm or malpractice that might occur. It would seem that the effort to prevent harm might be better regulated by creating a requirement for RTFs to use only procedures that have been medically reviewed for safety.

6. Section 23-203

This section requires the RTF to establish a written plan to create a "Restraint-Free environment". Since restraint may only be used for "emergency intervention", it seems to suggest that RTF environments will be using restraint interventions in "non-emergency situations" and therefore must become emergency-free.

Subsection (b.1.) requires that "trauma informed care" alternatives be used instead of "restraint". Trauma informed care alternatives to restraint that is being used in "nonemergency situations" makes sense – strategies such as "time-out", "redirection", "regrouping", "communication clarification", etc. are very appropriate for non emergency situations. However, I am not sure regarding trauma informed alternatives during "emergency situations". What trauma informed alternative would be used to stop one youth who is punching another? When hysterical young ladies fight, they pull hair, scratch eyes, bite and kick. What trauma informed strategies are suggested for these "emergency situations"? The goal of this section is to reduce restraints and restrictive procedures. If these interventions can only be legitimately used for emergencies, then the actual goal of this section might better be stated as reducing the frequency of "emergency situations". Trauma informed strategies are most commonly used prior to "emergency situations". This is to prevent trauma prompted behavior from escalating into an emergency situation.

In addition, it is worth noting that "Trauma" information can and should be used even when "emergency" strategies are employed. There are restrictive procedures that may be more or less appropriate depending on an individual's history. Whenever possible, emergency strategies should have a treatment orientation. This is particularly true with SIB (Self Injurious Behavior) incidents. For example "cutting" behavior and "head-banging" behavior require different responses.

Section 23.204

This section provides guidance on the use of "time-out". The document recognized "time-out" 23-201-b but does not include it as available in 23-201-c. Since it is specified here, I conclude that 23-.201-c is an omission or "time-out" is misconstrued.

Section 23-205

This section is titled "Emergency Safety Intervention" and includes a variety of prohibited strategies, e.g. mechanical, seclusion, prone, etc. Throughout this section the terms "emergency intervention", "restraint" and "restrictive procedures" are used interchangeably. This, I think, causes confusion. I suggest that the regulations focus on "emergency interventions".

The section continues with high specificity regarding intervention orders, implementation and documentation, all of which set in motion burdensome process for the RTFs. Perhaps the Department could develop a checklist and single documentation form to assist in this and to ensure some consistency in data collection across the field. Were this done, the regulation would simply have indicated that the Department would provide a process checklist and documentation form with tasks that must be completed for all emergency interventions as per HCFA (now CMS) rules.

Summary comment:

The RTF regulations provide numerous positive guidelines on "emergency interventions" that will benefit both consumers and providers. When the pages on the program issues in the document are counted, almost twenty per cent is devoted to "emergency interventions". Were the level of specificity applied to this area the same for other program topics, the document would be an A to Z treatment on residential care. One important area that is treated lightly in the proposal is suicide training and intervention. I believe our requirements here are less than needed. Child and adolescent suicide attempts result in many more tragic outcomes than restraint and seclusion interventions.

The HCFA (now CMS) rules regarding restrictive procedures are Federal mandates that have existed for sometime. While the process they require to initiate and implement an emergency procedure provide safeguard that helps to ensure appropriate practice, they present another problem. Emergencies occur in real time. Intervention in emergency situations, where "harm to self or others" is occurring, cannot wait for "permission". Staff who are "professionally trained" can make good decisions. They should be empowered to intervene and held accountable for the intervention. I remain opposed to the rigid construct of layered clinical decision making for "emergency situations". I believe this promotes negligence of duty and under-reporting of interventions.

Thank you for the opportunity to comment on this proposal.

Respectfully,

Joseph K. Mullen, MSW
President

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