3.16 Behavior Support and Management Child Welfare Services

PHILOSOPHY:

All children who are recipients of services from Child Welfare Services are entitled to and shall be treated with dignity and respect, in a culture that promotes healing and provides each child the support needed to manage his or her own behavior. This policy is inclusive and applies to all children served by Child Welfare Services and to the Provider Agencies who provide residential services under contract with the Department of Health and Human Services. This policy is in addition to existing state regulations, rules, and policies relating to behavior support and management.

DEFINITIONS:

Mechanical Restraint: Mechanical restraint is the immobilization of a recipient's arms, legs or entire body by the use of an apparatus that is not a medical protective devise.

Chemical Restraint: Chemical restraint is the use of medication, administered involuntarily, for the purpose of immobilizing an individual who is in imminent danger of self injury or harm to others.

Manual Restraint: Manual restraint is the use of recognized certified physical restraint methods such as Mandt or TCI to hold a recipient in a non-stressful position until the recipient is able to control his or her own behavior.

Seclusion: Seclusion is the involuntary placement in a room that is locked or held closed and from which exit is denied.

Isolation: Isolation is the involuntary placement of a recipient in a timeout/safe room to separate the recipient from others or an environment where there was potential of harm to the recipient or others. Staff must monitor the child on a random and regular basis, but at least every 15 minutes.

Time out: Time out is the voluntary placement of a recipient in a quiet non-stressful area. Isolation/safe rooms may be used for this purpose, but the recipient cannot be denied exit from the room.

2. Principles:

The principle regulating behavior support and management is clearly defined in the Rights of Recipients of Mental Health Services who are Children in Need of Treatment, and licensing regulations for Private Non-Medical Institutions and residential Child Care Facilities. All child welfare staff should receive training in these areas. All agencies

who operate under contract with DHHS are required to follow these regulations. The following policy is intended to provide guidance for child welfare staff for day-to-day decision making and to establish the action required when certain behavior management techniques are used.

Restraint and isolation procedures are utilized to maintain health and safety in situations where less restrictive measures are ineffective. Their use is based on the assessed needs of the individual client. When a client undergoes a behavioral intervention, the first question should be whether the use of the behavioral intervention could have been avoided. Each incident should be viewed as an opportunity to explore new methods to support the client in managing his or her behavior and an opportunity to explore methods to prevent future incidents. Following any behavior intervention the recipient should be provided the opportunity to process the event with staff. Each behavior intervention should be thoroughly documented and reported to the CWS caseworker with clear justification for the use of the specific intervention. Treatment plans should be flexible and adjusted often to respond each child's needs.

The client, family, guardian, and GAL where appointed, should be educated regarding staff use of restraint and isolation. All team members, including the child when developmentally appropriate, shall receive the written summary of the Behavior Support and Management policy and procedures. This includes biological parents, adoptive parents, foster parents, residential staff, guardian ad litem, and other team members. All team members shall receive a copy of the child's treatment plan, which should include any behavioral techniques that will be used as part of treatment.

All behavior plans shall be based on the results of an assessment developed by licensed clinical staff. Children and families should be asked what has worked best to de-escalate aggressive behavior for that child in the past. The plan shall identify strategies to help the person de-escalate behaviors and specify the interventions that may and may not be used. Any type of restraint or isolation shall not be use in response to property damage and only be employed when absolutely necessary to protect the child from injury to self or others, and only after less restrictive measures have proven to be ineffective. Restraints and isolation are never to be used as punishment, discipline, coercion and retaliation or for the convenience of staff.

3. Restraints

A. Mechanical restraints can only take place in a hospital under a doctor's order and supervision. The regulations managing those interventions are documented in the Rights of Recipients.
B. Chemical restraint can only take place in a hospital under a doctor's order and supervision. All other chemical interventions should be therapeutic in nature. Use of medication in a time of increased psychosis or aggression is not a restraint but appropriate use of medication as long as the goal is not physical immobilization.

C. Passive Physical Restraints are permitted only in children's licensed mental health residential facilities. Restraint is permitted in licensed treatment foster homes on an emergency basis only. Child welfare staffs may use physical restraint on an emergency basis if they have received the appropriate training. An emergency is defined as a situation where there is risk of imminent harm or danger to the individual or others. All residential and treatment foster care staff must be trained in a recognized and approved restraint technique and implement the techniques with fidelity. At no time may restraint be used as a form of punishment, discipline, to gain compliance or for the convenience of staff.
If physical restraint continues for more than thirty minutes, provider staff must call the Community Based Mobile Crisis Team and request a crisis assessment. The provider may continue the restraint until the crisis team arrives and during the assessment. The crisis team will conduct an assessment to determine if the client should be placed in a higher level of care, such as a hospital setting, or what other steps can be taken.

4. Isolation or Seclusion

A. The terms Isolation and Seclusion are used interchangeably in the various regulations governing behavioral management. Seclusion following the definition of in a setting/room where exit is denied is not permitted in residential facilities. Isolation is permitted in children's residential facilities that hold a mental health license.
B. A client may be lead/escorted involuntarily to a designated room that meets licensing regulations. A lock cannot be used to hold the door, but the door may be shut while the child is in isolation. The child must be monitored randomly but at least every 15 minutes by qualified staff. The door must allow visibility into the room if shut.
C. No child under the age of five (5) shall be isolated outside the view of a caregiver. Isolation shall be limited to thirty minutes. During the isolation the child must be randomly given a chance to remain calm and leave isolation. If staff feel continued isolation is warranted, the program supervisor must physically assess the child and the need for continued isolation.

5. Procedures

A. Child Welfare staff should be informed within one business day of all behavioral management interventions except time out. If the child has a legal guardian, they shall also be informed within one business day. Provider staff are required to submit an incident report that includes
    a. An assessment of the precipitating cause or reason for the behavior interventions.
    b. Documentation of the methods used (restraint or isolation), and the length/duration of the intervention
    c. An explanation of the less restrictive interventions tried prior to the behavioral intervention and why such measures were not successful

d. An assessment of the impact/effectiveness of the treatment plan and how it may need to be modified to prevent the use of behavioral interventions in the future.
e. The names of the staff involved and the supervisor who authorized the behavior intervention.

B. The child must be given a chance to process all behavior interventions. This processing should be part of the client's treatment. Clinical records should document the child concerns, his or her reflection on the effectiveness of the intervention and level his or her of understanding of the process.

C. For any behavior intervention that takes longer than one hour or which causes injury to the client or staff, the provider shall schedule a debriefing to review the behavioral intervention by the next business day. Child welfare staff shall be informed of the meeting and given the option to attend. The debriefing shall identify the antecedent behaviors that lead to the intervention and use this information to modify the treatment plan.

D. Child Welfare staff will enter the information in the child's record and designated database. At the end of each quarter, each district shall submit to Central Office a report documenting all behavioral interventions for review and analysis by the Senior Management Team.

E. A report is to be made to Central Intake of any restraint resulting in physical signs of injury or if the child is reporting they were hurt, or suffering resultant or persistent pain. The Institutional Abuse Unit will investigate where there is a physical injury apparent.

Current Regulations on Behavioral Support and Management of Children
CWS Regulations:

- Consent for Non Routine Medical Procedures (SecV.1-5, Pages 3-5 covers therapeutic holding and rebirthing)

CBHS Regulations:

- Rights of Recipients of Mental Health Services who are Children in Need of Treatment (applied to **all** children served in residential mental health faculties)
- Regulations Governing Emergency Interventions and Behavioral Treatment for People with Mental Retardation and Autism (Applied to **all** children with Mental Retardation and Autism)

Licensing Regulations: Please note that these regulations will be updated and reissued in the next year.

- Rules for Licensure of PNMI Residential Child Care Facilities (Sec. 4B-4, Pages17-19 and Sec. 6D, Pages 79-83)

- Rules for the Licensure or Child Placing Agencies (Sec. 23F-2, Pages 34-35)
- Rules for Licensure of Emergency Shelters for Youth (Sec. B-3, Pages 14-17)
- Rules for Licensure of Shelters for Homeless Children (Sec. B-5, Pages 8-10)
- Rules Providing for Licensure of Family Foster Homes for Children (Sec. 9-D, Pages 13 and 14, also applies to Treatment Foster Homes)

Dept. of Corrections Regulations:

- Behavioral Management Systems (DOC Regulations Chapter 15)

Dept. of Education Regulations:

- Regulations governing timeout rooms, therapeutic restraints and aversion in public schools and approved private schools (DOE Regulations Chapter 33)
- Maine Special Education Regulations (DOE Regulations Chapter 101, Pages 90-98)