Current Issues in the Containment of Dangerous Behavior

Merrill Winston, Ph.D., BCBA-D
Neal Fleisig, M.S., BCBA
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Airline Safety Quiz!

In the unlikely event that your aircraft should experience a sudden loss in cabin pressure, oxygen masks will drop from the overhead compartments.

After placing the mask over your nose and mouth, you begin to breathe normally and notice that the bag is not inflating.

Question: Is oxygen still flowing?
Airline Safety Quiz

A: Yes, Oxygen is still flowing freely, continue breathing normally

B: No, Oxygen is not flowing freely, begin to hyperventilate

C: I’m still confused about the whole seatbelt thing

D: I’m so overcome by panic at the mere thought of needing emergency oxygen that I have completely lost the capacity for rational thought
The Professional Crisis Management Association
www.pcma.com

- Professional Crisis Management training (PCM) to teach direct care staff and teachers how to Prevent/De-escalate pre-crisis behaviors and how to safely intervene with Crisis Behaviors

- BehaviorTools training, based on the work by Dr. Glen Latham, to improve interactions between staff and clients and students and teachers

- Individual case consultations for schools and residential facilities

- Expert Witnessing and critical incident analysis and prevention

- Pre-Packaged and Customized Software Solutions for Human Services
Overview

- Current Trends in the use of emergency interventions (particularly restraint)
- Misconceptions about emergency interventions
- Expectations of parents/advocates/others
- Pros and cons of various modes of intervention
Overview

- Programmatic Vs. Reactive Strategies
- Ways to reduce emergency interventions (good and bad)
- Litigation Issues (who, why, over what, how to prevent)
What are the current trends?

- Banning certain modes of emergency intervention (restraint and seclusion) and banning specific methods (prone holding, supine holding)
- Banning the use of interventions based on setting
- Banning the use of interventions based on diagnosis
- Banning the use of interventions based on age range
- Banning all emergency interventions
- To eliminate all restraint and seclusion or reduce them regardless of the methods used to attain the reduction
Misconceptions about restraint

- Restraint = Abuse
- Restraint = Punishment
- Restraint = Dangerous
- Restraint = Treatment Failure
Unreasonable Expectations

- All emergency interventions can be eliminated for an entire population of individuals

- There should be no injuries in the use of restraint. If there is even one significant injury, the restraint must be banned.

- Even if there are no physical injuries, there will be psychological injuries (trauma) that possibly can never be verified

- Behavior Analysis will work instantly

- A good clinician can prevent every crisis

- Behavior Analysis will eliminate every instance of unwanted behavior forever
Methods for the Containment of Dangerous Behavior: Pros and Cons

- Manual restraint, mechanical restraint, seclusion and chemical sedations all have strengths and weaknesses.
- All forms of restraint and seclusion pose risks to the client.
- NOT INTERVENING AT ALL carries risk as well.
- Some of the risks of not intervening at all are immediate and obvious and some are less obvious, with long-term effects that may not be seen for years.
Manual Restraint Pros

- Can be started immediately
- Can be terminated immediately
- Can be instantly changed as a function of behavior
- Staff MUST be present for its continued use, hence it is difficult for them NOT to monitor the individual
- The individual may learn to engage in “self-control” behaviors due to the presence of staff. This in turn MAY generalize to other authority figures
Manual Restraint Pros

Staff have a “vested interest” in making the restraint as brief as possible as the restraint becomes increasingly unpleasant for staff as they begin to fatigue (unlike mechanical restraint and seclusion)
Manual Restraint Cons

- People are not machines, they make errors
- People get tired (manual restraint is best done briefly)
- People get angry
- Physical contact may function as a huge reinforcer for some individuals under some conditions (deep pressure)
Manual Restraint Cons

Often times, manual restraint provides an IMMEDIATE REINFORCER for staff. As engaging in preventive measures often provides no immediate reinforcers (e.g., running behavior programs), staff may use restraint far too often.
Mechanical Restraint

What are the virtues?

- Mechanical restraints don’t get tired
- Mechanical restraints aren’t “pissed off” because the client tore their favorite shirt
- They typically will allow for a more complete immobilization by eliminating momentary escape as a reinforcer for struggling. People who can’t move very much will typically relax much more quickly
Mechanical Restraint

They are more appropriate when the person’s behavior may be maintained by physical contact from staff, when the individual is unusually strong relative to staff, or when the individual struggles for a long time.

Drawbacks:

- Its usage may appear barbaric to some.
- It does not change in real time as behavior changes.
Mechanical Restraint

- It may not be readily available, depending on the type of device
- It may be difficult to get the person into restraints and many people may get injured during this process
- It is difficult to fade and then reapply the restraints quickly
- It is possible to leave the person unattended which has in some instances lead to injury or death
What are the virtues of seclusion?

- Removes attention/physical contact as a reinforcer
- Allows a complete removal of the opportunity for aggression/property destruction, yet also allows for a greater freedom of movement
- Some individuals may calm more quickly when they are free to move around
- May be more appropriate for people who’s behavior is escalated by physical contact (more than usual)
Seclusion

What are the drawbacks?

Contraindicated for individuals with certain types of SIB

Freedom of movement can let some people escalate further (pounding on walls and the door)

Huge potential for overuse as staff do not get tired and feel safe from the person, and their response cost is typically lower when compared to utilization of manual or mechanical restraint
Seclusion

If using an actual seclusion room, it has limited availability and the client still requires a degree of physical restraint (usually a physical escort) to get them to the room.

For staff, exiting the room without injury can be challenging and there is the potential for door-related injuries when closing the door.

It can be easy for staff to leave the person unattended.
Chemical Restraints

There are chronic, and emergency “chemical restraints”

(Chronic) “Medications, unlike restraint, are easily softened under a veil of medical legitimacy that causes the general public to be more accepting of their usage. Unfortunately, the potential side effects are no less dangerous or deadly.”
Chemical Restraints

Chronic psychotropic medications (Chemical Abolishing Operations) easily “fly under the radar” and are much less “in your face” than other forms of behavior control.

The up-side of chronic psychotropic medications is that, if used properly, the individual is generally safer and easier to work with, making treatment easier.
Chemical Restraints

Staff may relax more and be less afraid of the person and less likely to react with physical interventions too quickly.

The drawbacks?

Chronic psychotropic medication usage may carry “side effects” that actually worsen behavior problems in a variety of ways. Some side effects may be permanent (TD) and some are life threatening (Adverse Cardiac Effects like Prolonged QT intervals, Neuroleptic Malignant Syndrome)
Chemical Restraints

Medications often have their effects by exerting a function altering effect on stimuli that typically produce problem behavior. Therefore an individual may simply not get angry anymore in the face of what used to be events that caused substantial physiological arousal.

Unfortunately, the problem is not that people get angry, the problem typically lies in what they do when they get angry. Getting angry is just fine.
Chemical Restraints

Medications that fail to stop all crisis behaviors may increase the risk of medical complications during physical or mechanical restraint that may be needed when medication has failed.

Almost without exception, individuals taking psychotropic medications still exhibit those behaviors for which the medications were originally prescribed.
Emergency Chemical Restraints

What about emergency medications?

Up-side: can be useful when the crisis is prolonged and with individuals for whom the use of any holding or seclusion is contraindicated or prohibited.
Emergency Chemical Restraints

Down-side of emergency medications:

- The latency between the onset of crisis and the administration of medication, may be far too long and efficacy is profoundly affected by the route of administration (Oral Vs. I.M.) and a variety of other factors.

- Medications can have wildly unpredictable effects.

- The person may be “out of commission” for hours after administration and cannot participate in active treatment.
Pros and Cons Summary

One of the biggest downsides of mechanical restraint, seclusion, and emergency psychotropic medications is that all 3 interventions are typically prohibited in most settings.

Manual restraint, although controversial, remains the most widely available means for the containment of dangerous behavior.
Programmatic Vs. Reactive Strategies: What’s the difference?

- Reactive strategies are sometimes referred to “emergency procedures”

- The “programmatic” use of restraint is not very well defined

- It may imply that some aspect of, what is typically an emergency procedure, is planned

- It may also mean that restraint is being used as a consequence that is not only designed to stop dangerous behavior that is occurring now, but is INTENDED to decrease the future probability of the behavior, whether dangerous or not
Programmatic Vs. Reactive Strategies: What’s the difference?

We find it useful to make two distinctions:

- The behavior in question is unpredictable
- The behavior in question is predictable, yet is not understood well enough to completely avoid all instances
Programmatic Vs. Reactive Strategies: What’s the difference?

- When behavior is unpredictable, there should be a good general guideline for intervention that is clearer than “danger to self or others”
- We use the notion of “continuous” behaviors of aggression and self-injury.
- We also use a guideline of continuous high magnitude disruption (significant property destruction, like throwing chairs for example)
When the behavior is predictable, one may continue to use general guidelines, but the predictable nature of the behavior, coupled with familiarity, may suggest modifications to general criteria that will better protect the individual and also prevent under-utilization and over-utilization of interventions.

This results in a customized definition of the need for intervention for that particular person based upon information collected about that individual.

Some people interpret this as a “planned” intervention, yet it is not the same as a mandatory 5 minutes of restraint for each instance of self-injury whether or not it was continuous.
Many parents, advocates and others are opposed to having emergency procedures written into IEPs for fear (presumably) that people will overutilize restraint, when in fact the exact opposite may be true.

A customized version of the criterion for intervention will always be superior to a general “danger to self or others,” but there must be adequate assessment and data collection to allow for its development.
What is the best way to reduce emergency procedures?

Peaceful Ranches Group Home

NO SECLUSION OR RESTRAINT FOR 35 DAYS!
What is the best way to reduce emergency procedures?

RestRAINT O’meter

1000
500
100

Restraints This month!
Our December Goal!
What is the best way to reduce emergency procedures?

Staff member 1: “Billy is hitting his head again, you need to stop him!”

Staff member 2: You go stop him, I’ve used up all my restraint minutes for the month!”
What are the best ways to reduce emergency procedures?

- Clinically Meaningful Reductions
- Illusion of Restraint Reduction
The Illusion of Reduction

The “Illusion” of reduction involves methods that either appear to reduce or actually do reduce the frequency of emergency procedures, however the methods used may actually reduce, delay or completely prevent long-term clinical gains.

- Prosthetic supports:
- Prosthetic Physical Environment
- Neutral Endangerment Residential Facility
The Illusion of Reduction

- Prosthetic Social Environment (tolerating the intolerable)

- Hitting is o.k.! We just tell staff to cover up the best they can until the attack is over!

- It’s ok to break stuff at our group home, we just keep a large supply of sheetrock and windows in the storage shed out back
The Illusion of Reduction

• “Have your staff pad themselves like the Michelin Man and let the individual hit them until they tire” (pun intended)
The Illusion of Reduction

- Hyper-palatable contingencies
- You get what you want, whenever you want it 24-7
- You are NEVER required to do anything you don’t want to do. We believe in FULL CHOICE for our clients!
- No changes are EVER made to your schedule
The Illusion of Reduction

- Increase in Medications
- Discharging the most challenging individuals/cherry-picking new admissions
- Definition of restraint games: e.g., it's not restraint if it's under 2 minutes
- Reporting games (under reporting)
- Policy games (Schools with “hands off” policies)
- Reinforcement of Pre-Crisis behaviors
Clinically Meaningful Reduction

- Teaching individuals with disabilities how to tolerate mild to moderate aversives that are encountered by all individuals in their daily lives.

- Teaching FUNCTIONAL replacement behaviors that are more efficient and produce the desired results more quickly and more reliably than their problem behaviors.

- Addressing gaping holes in the individual’s verbal and social repertoires.
Clinically Meaningful Reduction

- Reducing unnecessary coercive interactions
- Increasing quality of life through changes in personally meaningful social/environmental/medical variables
- Preventing over-utilization of emergency procedures by establishing good general guidelines for intervention coupled with specific criteria for predictable, analyzed behavior that has not yet been eliminated entirely
- Renaming “non-compliance” to “poorly motivated”
Clinically Meaningful Reduction

Properly addressing aberrant reinforcers that may reinforce crisis behaviors (clients who like to see blood, like to hurt people, like to see people become upset/angry)
LITIGATION

Litigation regarding emergency procedures, particular manual restraint, is on the rise as parents become more aware of restraint issues in both schools and residential facilities.
Who Sues and Why?

- Primarily Parents, either because there was a physical or psychological injury because of an improper restraint or because of a belief that the restraint was simply uncalled for.

- Sometimes it is a staff member who was physically injured by a client or teacher/student.
Who is the defendant?

- Typically the organization, not the individual practitioner. Organizations have deeper pockets.

- Privately insured individuals may be sued if the organization has sovereign immunity which typically carries a cap of 100k.

- Individuals may be charged with criminal offenses if there are allegations of outright abuse of some sort, but in most instances these are civil suits.
What is typically the legal basis for the suit?

- Negligence: Which takes the form of...
- Malpractice—failure to follow generally accepted standards
- Misfeasance—took inappropriate action—intervened when you should not have
- Malfeasance—hostile aggressive actions taken to injure the individual’s interests
What is the typical claim in the suit?

- Damages!
- Physical Injury
- Psychological Injury (harder to prove)
- Civil Rights Violation (a loop-hole to the whole sovereign immunity cap)
How often do cases go to trial?

- Only about 10% of civil suits go to trial. Most cases settle.
- Settling involves how much your liability insurance company wants to pay to make the whole thing “go away”.
- It usually involves assessing the costs of litigation.
- This is coupled with the cost of losing if a judgement is made against you.
- Then you figure in the probability of losing the case.
How do we reduce the risk of litigation?

- The biggest concern should not be how to win cases, but how to avoid being sued in the first place.

- “I was never ruined but twice, once when I lost a lawsuit, and once when I won.”
  --Voltaire
How do we reduce the risk of litigation?

- Get all interested parties “on board” before ever using an emergency intervention. If there are objections, it’s best to get them out of the way up front.

- This may involve assessing expectations and setting new ones if those expectations are wildly off base, e.g., all problems can be avoided, all behaviors can be de-escalated, behavior change is fast and occurs with no errors, and significant injuries should never happen during emergency interventions.

- Keep lines of communication open.
How do we reduce the risk of litigation?

- Make sure you can defend your decision to begin an emergency procedure if the average person would not agree with your decision.

- Make sure staff do not deviate from the procedures in which they were trained.

- If it is decided that a procedural modification is necessary, be ready to defend the use of that modification.
How do we reduce the risk of litigation?

- Document, document, document!
- Document what is being done to prevent crisis
- Document the use of emergency procedures
- Document Staff training
- Document Medical clearance for the use of emergency procedures
How do we reduce the risk of litigation?

- Document proof of progress!
- Increased access to community, movement to less restrictive settings/decreased staffing ratios
- Decreased frequency/duration/restrictiveness of the emergency intervention
- Increased functional skills that **directly** impact the probability of crisis behaviors
Thank You!