

The Truth About Prone Restraint

www.thetruthaboutpronerestraint.com

NOTICE AND COMMENT

Re: [Position Paper on the use of Restraint](#)

Dear Officers, Educators and Caregivers:

We write to comment on the current wave of pressure coming from special interest and advocacy groups regarding the use of restraint and seclusion and their attempt to coerce the ban of certain techniques or procedures. Advocates have been trying to ban restraint including prone restraint for quite sometime. This purpose of this paper is to put out the actual law, facts, statistics, realities and comments of the workers on the front lines dealing with challenging populations. There is a reason that the vast majority, including up to 90% of states, state agencies and their licensees still permit the use of prone restraint.

Our comments will include an overview of the law governing the use of restraint for both treatment and security purposes. We will also provide our expert analysis as well as actual comments from private facilities detailing the real impracticalities of maintaining a safe and therapeutic environment where prone restraint is not permitted.

In 1999 the Government Accounting Office (“GAO”) recommended that Centers for Medicare and Medicaid Services (“CMS”) work with the Food and Drug Administration (“FDA”) and Substance Abuse and Mental Health Services Administration (“SAMHSA”) to establish databases necessary to collect data on the use of restraint and seclusion. We wrote to CMS and SAMHSA to obtain restraint statistics stating “as a result of agency restraint reduction initiative and implementation of ineffective security measures, we are seeing that when the desire to eliminate or reduce restraint beyond a certain point exceeds the actual realities of the institution and population served, the following results occur including increases in the use of mechanical and chemical restraint, increase in worker and patient injuries, longer holding times, increased worker compensation and time off claims and an increase in assaults.”

We asked SAMHSA – an agency who has spent tens of millions of taxpayer dollars on restraint initiatives, studies and research -- for their restraint statistics to find out whether their research and statistics matched the data we were receiving. We also asked CMS and the FDA for their statistics on restraint. The agencies responded that they do not have restraint statistics.

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Therefore the information being disseminated by the advocacy organizations are not backed by any scientific or factual data. The information has a one-sided agenda – the rights of disabled and incarcerated persons being restrained without a corresponding concern for the rights of the other clients and students or the staff and educators caring and educating them. We urge that before you give up your or your employees rights and safety, that you consider the real life practicalities that providers are faced with daily, and their obligation to not only keep the client who is out of control safe, but to keep others in treatment and school safe. Not to mention the employee’s personal right to be safe from and protect him or herself from harm.

Overview

According to Federal law: the Constitution, Supreme Court and Circuit Court decisions, CMS regulations, HHS Departmental Appeals Board Decisions the appropriate standard for using of restraint as a safety intervention is that the restraint must be reasonable and effective to maintain safety. If restraint is used for treatment, the appropriate standard is that the restraint must be based on or as part of an individualized treatment plan ***based upon the professional judgment of the professionals who are directly involved in the consumer’s care and who are in the best position to assess his real needs.*** The legal concept of exercising professional judgment (toward the development of a sound and effective individualized treatment plan) does not refer to the judgment of bureaucrats operating from a remote location concerning a client who they have never met. Professional judgment refers to the persons with the necessary competency and skills necessary to develop the individualized treatment plan. This means that according to Federal law, it is the people educating and caring for the client or child on a daily basis that are responsible for his/her treatment, not the advocacy groups or bureaucrats operating from remote locations and the safety of their offices.

Supreme Court

Youngberg v. Romeo is the Supreme Court case that provides the proper standard for analyzing whether a patient’s rights had been adequately protected. In *Youngberg*, the Court determined then when deciding whether a patient’s civil liberties were infringed, that it was necessary to balance “the liberty of the individual” and “the demands of an organized society.” As an example, the Court explained, a patient’s right to freedom of movement would not be violated if the institution has to restrict that patient’s movement in order to protect the patient or others from violence. The Constitution only requires the Federal courts to determine that professional judgment was in fact exercised, it does not require the Court to second guess the professionals. Under the “professional judgment” standard, the decision whether to restrain or not to restrain, along with the degree of restrictiveness of the restraint necessary to ensure the safety of the patient, staff and others must be made by "a person competent, whether by education, training or experience, to make the particular decision at issue. . . ." *Youngberg*, 457 U.S. at 323.1

According to *Youngberg*, it is inappropriate for the federal courts or, by extension state agencies, to second guess the professionals. This ruling is further supported by the Department of Health and Human Services, its Departmental Appeals Board and the Centers for Medicare and Medicaid Services (CMS). All which agree that the responsibility for appropriately assessing

what intervention and support is necessary for the consumer or child rests with and is the responsibility of the institution.

CMS Restraint Regulations

In 2007, after extensive review and chance for public comment, CMS adopted the final rule on restraint usage. *See*, Patients' Rights Condition of Participation (CoP). The applicable CMS regulations are contained in 42 C.F.R. 482.13 Sections (e) and (f) which state in part that "(2) *restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient a staff member or others from harm. (3) The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.*"

In the public comment section, CMS offers guidance on dealing with a dangerous patient, stating:

"When a patient is exhibiting violent or self-destructive behavior and the patient is in danger of harming themselves or others, and less restrictive interventions have been determined to be ineffective, we expect staff to implement **appropriate** interventions to ensure the safety of the patient and others. While the steps described by the commenter may be appropriate in some situations, they may not be appropriate in others. For example, a patient is attacking another patient. In this situation, immediate intervention, that is, restraint or seclusion in conjunction with ongoing verbal de-escalation and communication with the patient may be necessary to ensure the safety of all involved. ***The use of less restrictive interventions that are ineffective in this scenario may, in fact, further jeopardize the safety of those involved. Therefore, it is critical that staff employ the least restrictive interventions that will be effective in ensuring the safety of the patient, staff and others.***"

(emphasis added).

Thus the standard for restraint use as set forth and codified by CMS is the least restrictive intervention method available where the intervention or restraint used is reasonable under the circumstances and effective enough to meet the real safety needs of the provider, workers and consumers.

Applications of restraint do not always take place in neat or convenient locations. Workers interact with consumers and visitors in other areas sometimes off grounds including field visits, community programs and transport and do become victims of assaults or witnesses to assaults on other workers, consumers or children by others with greater physical assets than themselves. There are countless of examples of employees who have been trained in inadequate crisis intervention and restraint programs. When faced with a consumer with greater physical assets than their own, these workers found that the intervention and restraint techniques they were taught were ineffective in maintaining a therapeutic and safe environment.

HHS Departmental Appeals Board ("DAB")

In *St. Catherine's Care Center of Findlay v. CMS* the DAB held that ***the institution itself is responsible for protecting the safety of patients and staff by providing sufficiently effective***

training to manage risk. Under Federal regulations facilities are required to "take reasonable steps" to ensure that a resident is supervised and kept safe from harm due to accidents. Assaults committed by residents who are out of control because of mental illness fall within the definition of accidents.

HHS held that the quality of care regulation (42 C.F.R. 482.13) requires facilities to provide supervision designed to meet the resident's real needs and protect residents from violent and dangerous behavior. The fact that the facility has some crisis intervention and restraint program in place is not enough. The program, training and staff response must be sufficient, capable and effective in maintaining a safe environment. In the case cited, the restraint program that was used only contained standing holds which were determined to be insufficient to maintain a safe environment.

ADA/504 and IDEA

While these Acts and statutes do not specifically address the use of restraint, the Courts and the Office for Civil Rights ("OCR") have recognized and upheld the use of restraint when done in accordance with a behavioral plan ("BP"), individual education plan ("IEP") or was necessary to maintain a safe environment. Based on Court rulings and OCR findings along with the wording of the statutes and Acts, the standard of intervention for students for treatment purposes is the professional judgment/ *Youngberg* standard.

Courts and administrative tribunals are disregarding policies and even written regulations that restrict a professional's ability to act in the best interests of the child or maintain safety. One California school created a no-restraint policy. One day a child was acting out in a manner that was unsafe and the teacher restrained the child. The school tried to discipline the teacher. The Court held that the teacher's use of restraint was appropriate and that regardless of any no-restraint school policy could use restraint when it was appropriate to do so.

In a similar situation a Georgia teacher was brought up on disciplinary charges for using an unauthorized form of restraint to maintain her personal safety. Georgia's administrative board held that the teacher's use of the intervention was justified and reinstated the teacher without penalty.

Schools have a quasi-special constitutional duty to maintain a safe environment and to protect children from harm while in school. Restricting a teacher's ability to protect him/herself or another or treat a child in accordance with an established IEP or BP, violates the teacher's and student's constitutional rights. Teachers should not have to be subject to termination or disciplinary hearings for stepping up to protect themselves or a student. Restricting their right and ability to do so is unlawful and does a disservice to everyone.

United States Government Accounting Office ("GAO") 1999 Restraint & Seclusion Report ("Report")

In 1999, the GAO investigated the use of restraint and seclusion in four states: New York, Massachusetts, Pennsylvania and Delaware. Based on an analysis of the information and reports attained from these States, the GAO was able to look at restraint incidents and isolate patterns.

In its Report, the GAO identified two particular behavior intervention techniques that resulted in incident patterns which were problematic. The first was the basket hold (the basket hold is a shorthand term referring to a particular type of restraint where a client's arms are crossed in front of their chest or stomach). The GAO found that the basket hold in a face down (prone) position where staff placed their weight on the back of a client whose arms were folded across their chest or stomach – a position the GAO coined as the “prone wrap” – was dangerous. The second restraint technique that the GAO found to be dangerous was the use of towels and other objects that were placed in clients' mouths by staff to prevent clients from spitting or biting. This technique was performed while the client was face-up. We make note that the GAO did not single out any other type of restraint or restraint technique or method as being particularly dangerous or problematic.

Most of the support of banning restraint and prone restraint comes from advocacy groups. There is no reputable scientific or research-based site that favors a blanket ban of restraint or prone restraint. The reason is that the cost to staff and client safety and treatment is severe and often not in the best interest of the client or child. Rather, the evidence-based studies favor restricting the use of techniques that place weight on the child's or client's back or chest or those techniques that have a proven track record of being unsafe such as the basket hold in the prone position and placing objects in client's mouths (identified by the GAO as dangerous). Any “official” prohibition that does not take into consideration both the engineering and safety record of the method in question is arbitrary and open to legal challenge on the basis of the United States Constitution, Federal laws, Supreme Court rulings and State self defense laws.

Equal Protection and An Individual's Right to Life and Liberty

The Declaration of Independence and the United States Constitution protect and preserve a person's non-waivable individual right to life and liberty and the right to protect that life and liberty using *all reasonable means* available. We assert that carefully engineered restraint methods including prone restraint that offer adequate mechanical advantage along with precautions that include continuously monitoring the physical and emotional safety of the person being held are both lawful and reasonable under the law. Whereas banning restraint or prone restraint for certain segments of the population where for example staff and teachers could not use certain methods to protect themselves or others, but others like law enforcement, volunteers, good Samaritans or other children would be able to is unlawful under the 5th and 14th Amendment of the United States Constitution.

State Self Defense Law

Indeed, State self defense law is determinative whenever a person presents a threat of imminent harm to self or another within its jurisdiction. The use of restraint including prone restraint is not only permitted but is, in fact, mandated under civil rights, state tort and State self defense law requiring staff to be able to act reasonably, effectively and in the best interest of staff, child and client. State law does not require anyone to submit meekly to the unlawful infliction of violence regardless of what mental condition may be causing the threatening behavior or the age of the actor. This right to self defense does not terminate when an employee of a facility arrives for work. Consumers and children also retain their right to self defense while on the organization's grounds.

A sworn officer responding to an emergency at a school or human service facility would not be prevented from using a prone hold in the course of containing and protecting someone, provided a reasonable and appropriate level of force was used. Human service workers and educators often have far less physical assets, capabilities or tools than the average officer and have an even greater need to rely upon physical techniques and holds that provide sufficient mechanical advantage to safely manage the entire spectrum of clients and students who may be much larger or physically capable than themselves. Human service workers at child care, residential treatment and many community services and field officers are not allowed to use chemical or mechanical restraints (i.e. handcuffs or soft restraints) to save themselves or others if their physical restraint program is insufficient. Neither the general public nor any self-respecting law enforcement officer in the United States would tolerate this level of intrusion into their own personal safety or heartfelt sense of duty to protect the children and patients under his or her care and supervision. Human services providers and educators deserve the same rights as every other citizen as long as the manner of intervention is least restrictive, effective and reasonable.

It has been shown that it is both foreseeable and inevitable that staff will need to use prone floor restraint to maintain safety, especially with the most difficult populations. The overwhelming majority of prone restraint catastrophes historically were either caused by improperly or non professionally engineered holding methods (i.e., the “basket hold”) or by spontaneously invented holds at the scene that either accidentally or deliberately became prone; typically by workers who were never trained how to properly restrain or monitor a child on the floor.

To consider all prone holding configurations equally dangerous is both naïve and without scientific merit, no matter how sincerely the belief is held by non expert advocates working from the safety of their offices. If you pile enough people on top of someone when they are being held supine (face-up), you will see identical outcomes as you would if they were prone. The real solution is avoiding methods that create chest compression and by creating policies that compel workers to continuously monitor the physical and emotional safety of the person being restrained.

Duty to Train

The Supreme Court has held that agencies, facilities and schools have an obligation to train their employees for the tasks they will face during their careers. As it is both likely and foreseeable that not every physical intervention can be maintained in a standing position, and that many physical interventions result in both the staff and child ending up on the ground often in a face-down position both intentionally and accidentally, the facility has an obligation to train staff how to handle this situation so as to protect themselves and others from harm. *Canton v. Harris*.

State Created Danger

State-created danger is found when a person's substantive due process protections -- rights, privileges, or immunities secured by the Constitution and laws i.e. the right to defend and protect oneself or another from bodily harm --are abrogated by the State. "If the state puts a man in a position of danger from private people and then fails to protect him, it will not be heard to say its role was merely passive; it is as much an active tortfeasor as if it had thrown him into a snake pit." *Bowers v. DeVit*. Among the historic liberties so protected is a right to be free from -- and

to obtain judicial relief for -- unjustified intrusions on personal security. *Ingram v. Wright*. The State does not have the right to limit a person's right to defend themselves or another in any manner that is reasonable.

Workers Compensation

Workman compensation is essentially a balancing act between the rights and responsibilities of both the employer and the employee. Workers give up the right to sue their employers in exchange for the guaranty that they will be compensated if they are injured on the job.

When a person's substantive due process protections -- rights, privileges, or immunities secured by the Constitution --are abrogated, the liability cap protections afforded to employers by State workman compensation laws are rendered moot.

In the case of restraint, there is a growing body of statistics clearly showing significant increases in staffing requirements, longer holding times per hold, the increased use of mechanical and chemical restraints, higher injury rates and a dramatic increase in worker compensation claims when prone restraint is eliminated from the training curriculum. One State Psychiatric Hospital had a 50% increase in their annual assault rate -- 600 additional assaults annually -- after it eliminated prone and floor restraint usage on its campus.

Staffing & Safety

Prohibiting the use of prone restraint would require facilities and schools to have additional staffing and security. To restrain a child face up on the floor requires four (4) (rather than 1 or 2) staff to be present for the safety of the child and the safety of the staff. This leaves staff and other children vulnerable if there is insufficient staff available. If two children are involved in an altercation, the school would need 8 rather than 2-4 staff to control the situation.

This corresponds to a 50% increase in staffing requirements. At facilities and schools caring and educating a population where prone restraint is necessary to protect the safety and welfare of the children, the elimination of prone restraint has resulted in higher turnover due to the fact that staff no longer feels safe within the facility or school, higher injury rates to staff and child, outplacement of the student to a more secure setting and more serious worker compensation claims. Teachers who were willing to intervene in the past, no longer feel safe using supine restraint, and have opted instead not to intervene and to call law enforcement or security. This leads to unfortunate headlines where police are being called in to maintain security at elementary schools and pre-teen students as young as five being led out of the school in handcuffs.

Conclusion

We respectfully request that you carefully consider the practical and legal ramifications of banning prone restraint. The majority of states and state agencies have NOT banned prone restraint, and have carved out exceptions for restraint usage and methods (face-up or face-down) that do not place weight on the client's back or chest. There is good reason that many State agencies have decided not to ban prone restraint as they observe other agencies and facilities that have banned prone restraint are noting significant increases in staffing requirements, longer holding times, use of ad-libbed, untested holds that are not in the best interests of the client, child

or staff, increased use of mechanical and chemical restraints, higher injury rates and increased and more significant worker compensation claims.

We also respectfully request that you carefully consider the legal ramifications of banning prone restraint including resorting to behavioral support interventions not administered in accordance with professional judgment; an individual's right to life and liberty and corresponding right to protect that life and liberty including those situations which fall under the cover of the State's self defense law.

We appreciate your attention and patience in allowing us to write on behalf of the organizations, workers and children we serve.

Sincerely,

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NATIONAL SCHOOL STATISTICS

Overview

There are currently over 100,000 schools serving 50 million students in this country. Violence in schools is therefore one of the most troublesome social problems in the Nation today.

In real numbers, no one really knows the extent of the threat in terms of school violence. There is no comprehensive, federally mandated or federal tracking of actual school crime incidents for K-12 schools. School crime and violence data by-and-large consists of a collection of a few academic surveys and research studies.

This means the American public is being significantly misled as it is estimated that between one and four out of five school crimes go unreported. Therefore the assaults against teachers are under-estimated between 20-80% and while assaults on teachers are high, assaults by one student against another students are higher and not adequately or accurately reflected in these statistics which are nonetheless disturbing.

Statistics

- Between 1997 and 2001, there were approximately 1.3 million reports where teachers were victims to nonfatal crimes at school. This includes 817,000 thefts and 473,000 violent crimes that were reported. On average, in each year from 1997-2001, about 21 out of every 1,000 teachers were victims of violent crime at school, and 3 out of every 1,000 were victims of serious violent crime (i.e., rape, sexual assault, robbery and aggravated assault. (These numbers are estimated to be under-reported 20-80%)
- Students between the ages of 12 and 18 were victims of about 764,000 violent crimes annually and 1.2 million crimes of theft at schools. (These numbers are estimated to be under-reported 20-80%)
- 13% of 9th graders reported that they were threatened or injured with a weapon on school property.
- Street gangs were reported present on school premises by 29% of students living in urban areas, 18% of students living in suburban areas, and 13% of students living in rural areas.
- 6.1% of students nationwide have carried a weapon (e.g., a gun, knife, or club) on school property one or more times during the 30 days prior to the survey. During the 12 months

preceding the survey, 9.2% of the students had been threatened or injured with such a weapon on school property one or more times.

- Each day, approximately 160,000 K-12 students don't attend school because they are afraid.
- 46% of students said they were hit, kicked, shoved, or tripped at least once in the previous month, and 18 percent had experienced this five or more times.
- One in fourteen students carries a weapon to school one or more days each month.
- 10% of traditional (non-special education) teachers reported being threatened with injury during a 12 month period.
- Nearly one in 10 high school students reported being threatened or injured with a weapon on school property during the preceding 12 months.
- Over 88% of victimizations that occurred at school against 12-18 year olds were not reported to the police.
- Of the 3,657 expulsions from bringing a firearm to school almost half were students in high school, 28 % were middle school and 24% were elementary school.

We recommend a copy of the publication: *Attacking our Educators, Stopping School Violence* <http://www.stoppingschoolviolence.com>.

Special Education

Special education advocates are especially touchy about the mentioning of violence in connection with students with disabilities. The data that exists puts the number of special education students around 14% of the total student population. This segment of students is the most rapidly growing segment and it is projected that special education students will soon represent 25% of the student population.

With respect to special education students and school violence, data shows that special education students committed threats at a significantly higher annual rate (33/1000 students) than regular education students (6.9/1000 students) and made more substantive threats (39.8%) than students in regular education (20%). Students classified as Emotionally Disturbed (ED) made the highest threat rates and the most serious threats. Students in special education who made threats also committed significantly more infractions involving violent acts. Research is showing that while

special education students represent approximately 14% of the school population, they are the source of 38-43% of the violent incidents.

Conclusion

Relinquishing your rights including such a basic and fundamental right as being able to use your professional judgment, protect yourself or someone else is never a good thing.

HEALTHCARE

According to NIOSH, every day 9000 nurses and healthcare workers are either verbally or physically assaulted on the job. In a survey of 170 university hospitals, 50% of emergency room employees were threatened by weapons during a 5 year period. In 2006, there were 506 people murdered while at work, nurses and pharmacists top the list of documented homicides. According to Department of Justice statistics, the average rate assaults in healthcare is 16.2/1000 for doctors; 21.9/1000 for nurses; 68.2/1000 for Mental Health Professionals and 69/1000 for Mental Health custodians.

Example 1

A survey of nurses and health professionals at a State Hospital found that 97% report staffing conditions that are dangerous, risking the safety of patients and staff; nearly 90% report working conditions (staff shortages, lack of training, lack of support from administrators) that prevent them from providing care up to their professional standards; nearly 80% report that they have/are considering leaving the facility because of unsafe conditions; 54% had been the victim of physical abuse at the hospital; and a shocking 97% of respondents know of a co-worker who has been the victim of on-the-job violence.

Example 2

In a 2004 survey of 6,300 randomly selected nurses, 13 percent of respondents reported having been physically attacked during the previous year and 39 percent reported having been threatened, verbally abused or sexually harassed. Patients accounted for almost all the physical assaults and two-thirds of the verbal ones, with visitors as well as physicians and other staff members responsible for the rest.

Example 3

One State hospital changed its restraint policy and discontinued the use of floor and prone restraint. That State hospital had a 50% increase in the number assaults – 600 additional assaults annually -- after the change.

Example 4

A Study of Patient Assault-Related Injuries in State Psychiatric Hospitals. Fifteen percent of participants at the 6 state psychiatric hospitals experienced a major to severe patients assault. What was interesting is that the results suggested that for a worker in a ward with low safety climate supervisory actions, the odds of experiencing a patient assault-related injury are 5 times greater than for workers in a ward with high safety climate supervisory actions. Another significant finding was that the odds of experiencing a patient assault-related injury was 2.5 times greater for respondents who believed that patient seclusion and restraint was not beneficial to use with patients. The implications of the study are that a high level of safety climate is protective for experiencing patient assault-related injuries. The study supports the contention that containment strategies are an important option for staff self-protection in psychiatric wards.

National Survey

Patient Assaults on Psychiatry Residents. Through a survey to directors of US psychiatry training programs, a study explored the prevalence of patient-related assaults on residents per responding program. The study found that most assaults were committed by male rather than female patients, and that patient assaults on psychiatry residents were apparently a frequent event during the course of training. The study found that the amount of psychiatric residents and psychiatrists assault rates were between 40-55%. Among psychotherapists, patient-related assault rates approached 40%. Among inpatient psychiatric nurses, who have the most ongoing patient contact, the rates were significantly higher.

Note

Even with these statistics, which are disturbing, it is estimated by some that these numbers account for only 20% of actual violent incidences as it is believed that up to 80% of violent incidents are not reported.

**EXCERPTS FROM COMMENTS RECEIVED WHEN A PENNSYLVANIA STATE
DEPARTMENT WAS CONSIDERING BANNING PRONE RESTRAINT**

Pennsylvania facilities can expect nearly a 40% increase in staffing budget to comply with proposed ban on prone restraint

Central Counties Youth Center submitted an impact statement relating to Pennsylvania-DPW proposed ban on prone restraint. The Chief Administrator for the Center stated that by using any technique other than a prone restraint would require four (4) (rather than 3) staff to be present for the safety of the child and the safety of the staff. Therefore, the Center would need to place additional staff on each shift for a total of 37% increase in staffing. The Center also predicts higher turnover due to the fact that staff will no longer feel safe within the facility, as supine restraint is not as safe for the staff or child as prone restraint is, along with corresponding worker compensation and child injury claims and lawsuits.

Pennsylvania facilities project changing hiring strategies as a result of the proposed ban on prone restraint from hiring Youth Counselors who are able to communicate and interact with kids, to hiring staff with more "muscle" to comply with the proposed ban on prone restraint.

Central Counties Youth Center said that in order to keep its staff and children safe if they can no longer use prone restraint they will have to hire larger staff, as some of the smaller Youth Counselors will not be able to maintain their own muchless the children's safety. So that the environment does not become one of fear where the children run the facility, these Youth Counselors will need to be moved to safer positions. Hiring practices will have to change from hiring Youth Counselors who are able to communicate and interact with kids appropriately, to hiring staff that will be able to physically handle a restrictive procedure if prone restraint is no longer remains an option.

Pennsylvania facilities increase their use of psychotropic medications due to prohibitive regulations on the use of physical intervention and holds.

Scott Spreat, Vice President of Woods Services cautioned that Stephanie Stolz, former head of the National Institute of Mental Health warned that over regulation of the practice of behavior modification was not in the best interests of the child. In Pennsylvania, which has placed high regulatory barriers restricting the use of applied behavior analytic strategies in our programs has resulted in reliance on psychotropic medications which has increased to almost double the national average among persons with intellectual disabilities. DPW's current approach is inconsistent with the prevailing trends in psychology.

We believe (as does the Supreme Court, the Department of Health and Human Services, Pennsylvania Law, Pennsylvania Community Providers Association (PCPA) and DBH) it is the credentialed professionals and/or professional organizations, not DPW that should define what is best for the child. Mr. Spreat further cautioned issuing a prediction of things to come, if administrators are to be scrutinized and questioned about every restraint use, individuals with significant behavior problems will be less likely to find placement in Pennsylvania programs. Clearly this is not in the best interests of anyone.

Pennsylvania facilities project an increase of worker and child injuries as a result of the

proposed ban on prone restraint.

Scott Martin, Commissioner of Lancaster County writes: DPW's actions banning prone restraint will negatively impact all Pennsylvania residential treatment facilities.

When a child engages in aggressive behavior, staff are trained to deflect punches and kicks and to get behind the child. From this point, if the child is still fighting, staff are trained to assist the child to a seated position. However, if this seated position cannot be maintained, there is a greater likelihood that this will transcend into a prone position. First, a staff member is not going to fall backwards, second it is a natural reaction to go belly-down. If the prone position is the natural progression of events in most restraint cases, why would we change that, forcing innocent individuals back into strike zones **or causing injuries to the joints of the child** [trying to turn her over or stand her up.] When a child is in the prone position, they pull their arms in tight in most cases and resist them from being pulled out. **In order to get out of the prone position, and into a supine position, our staff would need to apply extreme torque on the child's shoulder, wrist and elbow joints, just to get them onto their backs.**

When a child is on their backs in the supine position during a restraint, you are affording them a position of power to inflict harm. Being in the supine position enables them to be more successful in punching, scratching, eye-gouging, pulling hair, biting and spitting. The most frightening tool they gain, is their ability to strike with their knees or legs. Unlike the prone position, the supine gives full leg striking ability which has led to many serious injuries to staff members.

By making these environments more dangerous, we will see more worker compensation claims because of staff injuries, and more lawsuits stemming from unnecessary injury caused to staff [as the state is creating a constitutionally dangerous condition] and child because [we could not maintain a safe environment] or by attempting to torque them into the supine position, out of the safer prone position.

If a resident strikes a staff member, bites, spits, hair pulls, knee kicks, they will be charged with aggravated assault. When a child is placed in the prone position, they are limited in their ability to further assault. When you place them supine, you give them every opportunity to do so. This increases the criminality of the child.

With regard to our female population, Many of these ladies have been raped or sexually abused prior to their involvement in the system. ***To make it a policy that these females would have to be restrained on their backs with a staff member, many times male, on top of them will undoubtedly result in re-traumatization.***

Prone restraints are safe if you transition youth to restrictive procedures that remove bodyweight off an assaultive child as soon as possible while continuing to monitor the physical and emotional well-being of the child.

Pennsylvania facilities project an increase in worker compensation and child injury claims as a result of the proposed ban on prone restraint.

James Jones, Administrator writes: The cost of workers compensation will increase due to more

injuries to staff. When a kid is in a prone position, his abilities to continue to struggle or assault staff in any way decreases. In the supine or in a seated position, the possibilities of a kid continuing to act out are greater and so is the possibility of injuries. In the supine or seated positions, kids can still kick, spit, bite or head butt staff easier than in a prone position resulting in injuries. With the increase in the number of kids with life threatening diseases (HIV, Hepatitis, MRSA), more testing will need to be done with staff after a restraint. I would expect an increase in my worker's compensation premium of at least 15%. This does not include the coverage for shifts for a staff who may suffer an injury during a restraint procedure

Scott Martin, Commissioner of Lancaster County writes: When a child is on their backs in the supine position during a restraint, you are affording them a position of power to inflict harm. Unlike the prone position, the supine gives full leg striking ability which has led to many serious injuries to staff members. By making these environments more dangerous, we will see more worker compensation claims because of staff injuries, and more lawsuits stemming from unnecessary injury caused to staff and child by attempting to torque them into the supine position, out of the safer prone position.

Pennsylvania Community Providers Association (PCPA). In some cases it is not in the best interests of the child to be placed face up. Some children and adolescents, especially those who have experienced physical violence or sexual abuse, may feel much more vulnerable and “exposed” when restrained in a face up position. This may actually contribute to a stronger and more dangerous reactive behavior from the child, an increase in the time it takes to deescalate the crisis, and a more significant impairment in the supportive and therapeutic relationship between the child and the staff.

Pennsylvania facilities project longer holding times and increased trauma to children who feel “exposed” when being held face up

Pennsylvania Community Providers Association (PCPA). PCPA and its members have long supported efforts to improve practices related to behavioral crisis management. In some cases it is not in the best interests of the child to be placed face up. Some children and adolescents, especially those who have experienced physical violence or sexual abuse, may feel much more vulnerable and “exposed” when restrained in a face up position. This may actually contribute to a stronger and more dangerous reactive behavior from the child, an increase in the time it takes to deescalate the crisis, and a more significant impairment in the supportive and therapeutic relationship between the child and the staff.

We believe (as does the Supreme Court, HHS, DBH, and Woods Services) that the crisis professionals interacting with the child on a day-to-day basis is the best person to devise a treatment and behavioral plan for the child [to find otherwise would violate the constitutional rights of the child]. In these circumstances the professional should be allowed to prescribe a safe and proven therapeutic face down approach that includes a technique and other elements of the plan that insure that the child is kept safe from pressure on the chest (back) or abdomen.

PCPA is concerned and disappointed that DPW has relied as the sole data on an advocacy based web site, rather than a more credible source like the Government Accounting Office Report from September 1999. PCPA finds the reference to and use of information from this advocacy group, rather than a credible academic or governmental source to be highly questionable. We

strongly recommend that DPW finds a more credible source of data.

Central Counties Youth Center also believes that the use of the supine position is more traumatic on youth, especially kids who have had issues of sexual assaults in the past. This position leaves kids feeling more exposed and gives them the feeling of being violated. In addition, since the child is face up, it does not allow him to de-escalate due to being able to see and interact with what is happening around her. The prone position allows the child the space to compose himself without losing his dignity and respect, and we have found that children have been able to compose themselves quicker when placed in a prone position.

Pennsylvania juvenile facilities project an increase in the use of handcuffs and shackles to comply with the ban on prone restraint.

County Commissioners Association of Pennsylvania. As a result of the ban of prone restraint, facilities are reporting an increased use of mechanical restraints for the more violent youth. They are experiencing staff hesitancy in confronting inappropriate behaviors as staff report fear of retaliation from licensing representatives should the confrontation result in aggressive behavior by the resident and a subsequent restraint should occur. The biggest and most potentially dangerous adolescents are then likely to become bullies and use intimidation, believing that they will not be held accountable or they can easily claim they have been abused by staff when they themselves become physically aggressive. This situation has resulted in resident youth willing to push limits further and thus increase the potential of harm to other residents and staff.

As a result of the lack of alternatives for the most physically challenging youth, we have begun to see a shift in employee response to include an increase in police reports, an increase in the use of mechanical restraints, and a decrease in staff willingness to work in detention facilities. Bargaining unit representatives have encouraged staff to pursue criminal charges on youth who become assaultive. Staff self-preservation and safety needs will take precedence over the juvenile's needs for treatment, supervision and rehabilitation based on staff's need to protect themselves.

Pennsylvania facilities foresee an increase of criminal charges filed against children.

James Jones, Administrator. With the increase in possible injuries to staff, will come an increase in charges being filed against the kids. In the past, staff would accept some injuries as part of their position, but that has changed. Staff now expect Administration to call in Law Enforcement when they receive any injury during a restraint for the possibility of filing criminal charges against the child. With a supine or seated restraint, more injuries are going to be incurred by staff [and child] which will result in more charges being filed against kids. This will increase the length of stay and it will make kids more difficult to place.

Juvenile Detention Centers Association of Pennsylvania. As a result of the lack of alternatives for the most physically challenging youth, we have begun to see a shift in employee response to include an increase in police reports, an increase in the use of mechanical restraints, and a decrease in staff willingness to work in detention facilities. Bargaining unit representatives have encouraged staff to pursue criminal charges on youth who become assaultive.

Other State Juvenile Facilities

Example No. 1

One State juvenile department recently changed its physical intervention policy to where staff are no longer able to intervene when youths are destroying property. This department also attempted to adopt a non-physical intervention policy. As a result of these policy changes, assaults at the various juvenile facilities are at unprecedented 25 year levels, and the number of workers out on workers compensation is as high as 60%.

Example No. 2

Another State juvenile department also tried adopting a non-physical intervention policy. Here again, assaults escalated to unprecedented levels and worker compensation claims were such that the State was paying 7 years of worker compensation for every year worked.

Example No. 3

In response to a restraint programming change in late 2007 that does not allow juvenile facilities to use prone restraint newspapers are reporting that -- Injuries in Maryland Juvenile Justice Facilities Spike in 2008.

From January to October 2007, there were 1,299 reported injuries in Maryland's state-run and privately-operated juvenile facilities, according to the most recent data available on StateStat, the state's statistics-based government management program that was implemented in early 2007. From January to October 2008, the Department of Juvenile Services reported 2,447 injuries in its facilities, an 88 percent increase from the previous year.

Incidents within the facilities have also increased almost 20%.