ALIGNMENT

nonviolent crisis intervention
a CPI specialized offering

New York 14 NYCRR Section 526 New York Department of Mental Hygiene – Office of Mental Health

Correlation to Crisis Prevention Institute's (CPI) *Nonviolent Crisis Intervention*® training program

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Correlation to Crisis Prevention Institute's (CPI) *Nonviolent Crisis Intervention*® training program

CPI commends the New York Department of Mental Hygiene for adopting changes to NYCRR Section 526 which update regulations governing the use of restraint and seclusion in facilities operated or licensed by the Office of Mental Health.

For over 33 years, CPI has supported organizations that strive to become restraint-free. Not only will the *Nonviolent Crisis Intervention*® training program meet the expectations outlined in NYCRR Sections 27 and 526, but CPI's train-the-trainer program and its family of advanced programs also offer a comprehensive array of curriculums that can meet a broad range of needs of facilities in the state of New York licensed and operated by the Office of Mental Health. CPI's *Nonviolent Crisis Intervention*® training program supports a restraint-free environment with an emphasis on crisis intervention and verbal de-escalation techniques to better assist staff with achieving this goal.

Additionally, by participating in the *Nonviolent Crisis Intervention*® program, staff will gain the skills and confidence necessary to handle crisis situations with minimal anxiety and maximum security. The training will help staff intervene more safely when behaviors become dangerous, and most importantly, it won't damage the therapeutic bond staff have worked so hard to establish with the patients in their care.

The following chart is designed to assist you in identifying some of the ways in which CPI's *Nonviolent Crisis Intervention*® training program can help the facilities licensed and operated by the Office of Mental Health in the state of New York develop policies and procedures in relation to the prevention and reduction in the use of physical restraint and seclusion. It will also assist in identifying areas that may require a review and/or revision in your facility's current policies and procedures.

Program Alignment

14 NYCRR Section 526.4 Restraint and Seclusion (a) Definitions
(1) **Behavior management plan** – a document that identifies a patient's individual preferences and behaviors related to behavioral management interventions, (e.g., an individual calming plan, an individual crisis prevention plan, or a personal safety plan).
(2) **Commissioner** – the Commissioner of Mental Health.
(3) **Drug used as a restraint** – a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for a patient's medical or psychiatric condition, or as otherwise defined in federal regulations of the Centers for Medicare and Medicaid Services.
(4) **Emergency** – a situation in which a patient's behavior creates an imminent threat of serious injury to the patient or another person, where there is the present ability to effect such harm. For purposes of this section, a threat to property shall not be considered an emergency.
(5) **Facility** – a hospital as defined in Section 1.03 of the Mental Hygiene Law, and shall include the hospital sub-class of residential treatment facilities for children and youth, as defined in such Section.
(6) **Manual restraint** – the use of a manual or physical method to restrict a person's freedom of movement or normal access to his or her body. The term "manual restraint" means and includes the term "physical restraint."
(7) **Mechanical restraint** – an apparatus which restricts a patient's movement of the head, limbs, or body, and which the patient is unable to remove, provided, however, this term may also apply to an apparatus not normally used for this purpose, such as a bed rail or bed sheet, if the patient is not able to release the mechanism.
(8) **Mechanical support** – a device intended to keep the person in a safe or comfortable position, which the patient can remove at will, or to provide the stability necessary for therapeutic and preventive measures such as immobilization of fractures, administration of intravenous solutions or other medically necessary procedures.

14 NYCRR Section 526.4 Restraint and Seclusion (a) Definitions
(9) **Nurse** – a registered professional nurse employed by, or rendering services in, a facility certified by the Office of Mental Health, who is currently licensed pursuant to article one hundred thirty-nine of the Education Law. (10) **Office** – the New York State Office of Mental Health. (11) **Physical escort** – the use of a light grasp to escort a patient to a desired location, which the patient can easily remove or avoid. (12) **Restraint** – any manual method, mechanical device, or pharmacologic measure which immobilizes or reduces the ability of an individual to freely move his or her arms, legs, body, or head. For purposes of this Part, "restraint" means and includes manual restraint, drug used as a restraint, and mechanical restraint. (13) **Seclusion** – the involuntary confinement of a patient in a room or area where the patient is prevented from leaving (or where the patient reasonably believes that he or she will be prevented from leaving), with no ability to meaningfully interact with other patients or staff, provided, however, it shall not mean confinement on a locked unit or ward where a patient is with others. (14) **Time out** – a voluntary procedure used to assist a patient in regaining emotional control by providing access to a quiet area or unlocked quiet room away from his/her immediate environment.

§ 526.1 –Background and Intent	Correlation With *Nonviolent Crisis Intervention*® Training Program
(1) Consistent with its statutory mandates, among the goals of the Office of Mental Health for the provision of care to persons with mental illness are the assurance of a safe and therapeutic environment, the reduction of danger, and the prevention of violent behavior.	(1) CPI commends the New York State Office of Mental Health for its comprehensive and well-written rule. For over 33 years, CPI has empowered organizations to provide the best possible *Care, Welfare, Safety, and Security*SM to their staff and all those they serve.
(2) Restraint and seclusion historically have been used in psychiatric facilities to manage episodes of violent or dangerous patient behavior. Statistically, these emergency interventions are associated with increased risk of injury to not only patients, but also to staff who utilize these interventions. Restraint and seclusion also may have deleterious effects on patients, including survivors of sexual trauma and/or physical abuse, and patients with hearing impairments who are unable to communicate without the use of their hands. Physical risks include serious injury or even death, and psychological injuries include re-traumatization for individuals with histories of abuse.	(2) CPI shares the Office's belief that the use of restraint and seclusion can pose significant physical, psychological, and social risks for both staff and patients. As a result, we teach that restraint or seclusion should be used only as a last resort when the danger being presented by the acting-out person's behavior outweighs the risks of restraint/seclusion use. Every *Nonviolent Crisis Intervention*® program includes an open discussion of the risks inherent in the application of restraint and seclusion, with particular emphasis placed on the ways staff can recognize and minimize these risks during an intervention.
(3) The use of restraint and seclusion to manage violent or self-destructive behavior can be significantly reduced through the creation and maintenance of an environment which promotes the empowerment of patients, identifies and implements strategies to advance positive behavior management and restraint reduction efforts, is strength-based and trauma informed, incorporates strategies in hiring or workforce development practices to advance these efforts, and emphasizes the education and sensitization of staff regarding the appropriate use of restraint and seclusion.	(3) For decades, CPI has supported organizations that strive to become restraint-free. Backed by unmatched customer service, supports, and resources, CPI's philosophy of providing for *Care, Welfare, Safety, and Security*SM can help transform cultures of care that are supported by an organization's leadership and commitment to becoming restraint-free. As part of those efforts, CPI advocates for interventions that are grounded in knowledge of the patient's history, with current information on any contraindications to their use. Whenever possible, a person-centered approach honoring the patient's preferences is preferred.

§ 526.1 –Background and Intent	Correlation With *Nonviolent Crisis Intervention*® Training Program
(4) It is the policy of the Office of Mental Health to achieve an ongoing reduction in the use of restraint and seclusion in facilities operated, certified, or monitored by the Office, with the goal of reducing restraint and seclusion to the status of rare events, to reduce the behavioral emergencies that have prompted their use, and, wherever possible, to entirely eliminate the use of restraint and seclusion.	(4) CPI has worked with thousands of organizations that seek to reduce and/or eliminate the use of seclusion and restraint. Through these relationships, we have developed expertise and insight that empower us to assist facilities in achieving these outcomes. With CPI's support and a commitment to reviewing restraint and seclusion practices and debriefing and evaluating their use as part of an ongoing Training Process, facilities are well-equipped to reduce or eliminate the use of restraint and seclusion.

§ 526.4 (b) General Principles	Correlation With *Nonviolent Crisis Intervention*® Training Program
(1) Purpose of intervention. (i) Management of violent or self-destructive behavior. Restraint and seclusion are safety interventions which may be used for purposes of managing violent or self-destructive behavior only in emergency situations if such intervention is necessary to avoid imminent, serious injury to the patient or others, and less restrictive interventions have been utilized and determined to be ineffective, or in rare instances where the patient's dangerousness is of such immediacy that less restrictive interventions cannot be safely employed. Such restraint or seclusion shall only be used for the duration of the emergency.	(1i) CPI's *Nonviolent Crisis Intervention*® training program is grounded in a philosophy of *Care, Welfare, Safety, and Security*SM for all staff and patients. In keeping with that philosophy, we stress that restraint and seclusion should only be used as a last resort when a patient presents an imminent risk of physical harm to self or others and when less restrictive interventions have been tried and have failed. Due to the high risks associated with the use of restraint, CPI teaches that restraint should be used only when the danger being presented by the acting-out behavior outweighs the risks associated with the use of restraint. This ongoing risk assessment is embedded throughout the *Nonviolent Crisis Intervention*® curriculum, with particular attention dedicated to it during the physical components of the course.
(2) Restraint or seclusion for any purpose shall never be utilized as punishment, for the convenience of staff, to substitute for inadequate staffing, or as a substitute for treatment programs.	(2) CPI fundamentally agrees with the Office's position that restraint should never be used as compensation for insufficient staffing, as a substitute for treatment, as punishment, or for the convenience of staff.
(3) In choosing the form of intervention for any purpose, staff shall utilize the least restrictive type which is appropriate and effective under the circumstances.	(3) When a physical restraint is used, CPI emphasizes that the least restrictive intervention that is appropriate and effective be applied. CPI's *Nonviolent Physical Crisis Intervention*SM includes a variety of physical skills that allow staff to increase or decrease the restrictiveness of an intervention, empowering them to adjust their response to the risk posed by the behaviors presented during the crisis situation.

§ 526.4 (c) Restraint and seclusion to manage violent or self-destructive behavior	Correlation With *Nonviolent Crisis Intervention*® Training Program
(1) General conditions for use: (i) The use of restraint and seclusion to manage violent or self-destructive behavior in a facility must be in accordance with the written order of a physician and selected only when: (A) less restrictive measures (including any such interventions that have been identified in a patient's behavior management plan), have been utilized and found to be ineffective to protect the patient from seriously injuring self or others.	(1) CPI's *Nonviolent Crisis Intervention*® training program is grounded in a philosophy of *Care, Welfare, Safety, and Security*SM for all staff and patients. In keeping with that philosophy, we stress that restraint and seclusion should only be used as a last resort when a patient presents an imminent risk of physical harm to self or others and when less restrictive interventions have been tried and have failed. CPI's *Nonviolent Crisis Intervention*® training program focuses on recognizing the early warning signs of potential crisis situations and equips staff with safe and effective nonverbal and verbal strategies for de-escalation, thus avoiding the potential need and use of physical restraint altogether. Additionally, a range of interventions are taught within the *Nonviolent Crisis Intervention*® training program, allowing staff a full continuum of strategies to ensure the use of the least restrictive intervention.
(3) Limitations: The following restraint techniques shall not be utilized in any facility subject to the provisions of this Part: (i) any technique that obstructs a patient's respiratory airway or impairs his or her breathing or respiratory capacity, including techniques in which a staff member places pressure on a patient's back or places his or her body weight against the patient's torso or back; (ii) a technique that utilizes a pillow, blanket, or other item to cover the patient's face; (iii) use of any technique on a patient who has a known medical or physical condition where there is reason to believe that use of such technique would endanger the person's life or significantly exacerbate the person's medical condition; or (iv) restraint in a prone (face down) position.	(3 i-iv) CPI acknowledges that some restraint positions are more dangerous than others. The physical restraint positions taught in *Nonviolent Crisis Intervention*® are designed to be nonharmful through keeping the patient in a safer, standing position while also avoiding any pressure on the patient's back or torso that could interfere with the patient's ability to breathe. None of the physical techniques taught in the program utilize any items that could obstruct the patient's airway or otherwise interfere with breathing. CPI advocates for physical interventions that are grounded in knowledge of the patient's history, with current information on any contraindications to their use. This information should be incorporated into the risk assessment inherent in the decision to use a physical restraint. In every *Nonviolent Crisis Intervention*® program, the Instructor addresses the risks of restraints and how to reduce them. To complement this discussion, each participant is provided with a workbook that includes a detailed addendum on understanding and minimizing the risks of restraints, with special attention dedicated to the risks of prone restraints, as well as any other restraint technique that can interfere with the patient's ability to breathe.

§ 526.4 (c) Restraint and seclusion to manage violent or self-destructive behavior	Correlation With *Nonviolent Crisis Intervention*® Training Program
(8) Release: A patient shall be released from restraint or seclusion as soon as such restraint or seclusion is no longer needed to prevent the continuation or renewal of an emergency.	(8) The units on physical intervention emphasize the goal of continually assessing the patient for signs of Tension Reduction, or a return to rationality. Evaluating the patient for signs of Tension Reduction enables staff to discontinue the seclusion or restraint as soon as the patient in crisis is no longer an immediate danger to self or others.
(10) Post Event Analysis and Debriefing Activities: A facility shall ensure that post event analysis and debriefing activities, occur after each episode of restraint or seclusion in order to determine what led to the incident, what might have been prevented or curtailed it, and how to prevent future episodes.	(10) A consistent variable in all instances of successful restraint and seclusion reduction (or elimination) is mandatory patient and staff debriefing. In *Nonviolent Crisis Intervention*® training, CPI offers a model for debriefing that can be utilized with patients, the staff members that were involved, or with any bystanders or witnesses to the event. This Postvention process creates a learning opportunity for everyone. It enables patients and others involved in the crisis to express their views on the situation and create a plan for preventing the acting-out behavior in the future by identifying the Precipitating Factors of the event and by planning alternative strategies for managing similar situations in the future. Staff can use the debriefing model to analyze each incident to assess their intervention strategies, identifying what worked well and what might be adapted to prevent future occurrences of the acting-out behavior. Additionally, staff can watch for trends or patterns of Precipitating Factors that may be related to staff approaches or the environment. Once patterns are identified, staff can use their analysis to inform policy development, make environmental changes when appropriate, and improve professional development practices for staff.
(11) Education and training: (i) All staff who have direct patient contact must have ongoing education and training, and must demonstrate competence in the techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion, and in the proper and safe use of seclusion and restraint application.	(11) CPI emphasizes that training is an ongoing process that should include, at a minimum, annual re-training for all staff. CPI also encourages organizations to create pass/fail criteria for the course that includes attendance, agreement with the program philosophy, written and physical competency testing, and demonstration and participation in nonverbal, verbal, and physical de-escalation strategies. Competencies should be consistent with other organization protocols. CPI also recommends the following as part of the ongoing Training Process: reviews, practices, rehearsals and drills, situational applications, policy discussions, and formal refreshers. Integrating these Training Process components assists in reducing training drift and affords staff the opportunity to problem solve difficult situations they face on a regular basis. CPI offers a variety of resources and tools that can be used to implement a flexible and effective ongoing Training Process in any facility.

§ 526.4 (c) Restraint and seclusion to manage violent or self-destructive behavior	Correlation With *Nonviolent Crisis Intervention*® Training Program
(12) Policies and procedures: Facilities operated or licensed by the Office which are authorized to utilize restraint or seclusion to manage violent or self-destructive behavior shall have policies which clearly articulate restraint reduction as an organizational value, set forth the organization's intent to advance positive behavior management and restraint reduction efforts, and specify the conditions under which restraint and seclusion shall be used, and the procedures for the initiation of such use to manage violent behavior that places the patient or others in danger.	(12) The *Nonviolent Crisis Intervention*® training program is built upon the information taught in the CPI *Crisis Development Model*SM. This model establishes a framework for assessing crisis situations and determining when staff should utilize physical interventions. CPI strongly suggests that an organization have written policies and procedures regarding who has authority to physically intervene, how that decision is made, and when the physical intervention will be discontinued, as well as which techniques staff are authorized to utilize. CPI recommends that an organization review its policies on a regular and ongoing basis to ensure that policies are in accordance with not only best practice standards and guidelines but also legislative regulations. CPI also recommends that its Certified Instructors incorporate this information directly within their training of the *Nonviolent Crisis Intervention*® program so as to keep all staff informed of these rules/regulations.