ALIGNMENT

nonviolent crisis intervention
a CPI specialized offering

The *Nonviolent Crisis Intervention*® Training Program and the Ohio Department of Mental Health Administrative Code Chapter 5122-26-16 Seclusion, Restraint, and Time-Out

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The following chart is designed to assist you in identifying some of the ways in which CPI's *Nonviolent Crisis Intervention*® training program can assist your facility in meeting the standards proposed by the **Ohio Department of Mental Health Administrative Code Chapter 5122-26-16 Seclusion, restraint and time-out**.

5122-26-16 Seclusion, restraint and time-out	Correlation With *Nonviolent Crisis Intervention*® Training
(A) The provision of a physically and psychologically safe environment is a basic foundation for effective mental health treatment. Adopting trauma informed treatment practices, creating calm surroundings and establishing positive, trusting relationships are essential to facilitating a person's treatment and recovery. The goal of reducing and minimizing the use of seclusion and restraint is one that must be shared and articulated by the organization's leadership. The elevation of oversight by leadership of each use of seclusion or restraint in order to investigate causality, ascertain relevancy of current policies and procedures, and identify any associated workforce development issues, is core to the successful achievement of this goal. These methods are very intrusive techniques to be used by trained, qualified staff as a last resort in order to control dangerous and potentially harmful behaviors and to preserve safety. Best practices include careful early assessment of a person's history, experiences, preferences, and the effectiveness or ineffectiveness of past exposure to these methods. Use of seclusion or restraint must be subject to performance improvement processes in order to identify ways in which the use of these methods can be decreased/avoided and more positive, relevant and less potentially dangerous techniques used in their place. When individuals experience repeated or sustained use of these methods, leadership should evaluate all causative factors and consider alternative treatment interventions and/or possible transfer to/placement in a more structured treatment setting with the capacity to meet individual needs with reduced exposure to these intrusive interventions.	CPI commends the Ohio Department of Mental Health for its comprehensive and well-written rule. For 30 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 this new Chapter, the program and its family of advanced programs also offer a comprehensive array of curriculums that can meet all the needs an organization has for supporting a trauma-informed environment with trauma-informed practices for behavior management. 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. CPI shares the Department's belief that the use of restraint and seclusion is intrusive and should be avoided at all costs. 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. Interventions should be grounded in knowledge of the person's history, with current information on any contraindications to their use. Whenever possible, a person-centered approach honoring the individual's preferences should be implemented. A commitment to reviewing the use of restraint and seclusion practices, and debriefing and evaluating their use as part of an ongoing training process, will help organizations reduce or eliminate the use of restraint and seclusion within an organization.

5122-26-16 Administrative Code- Key Definitions
(1) **Advance Directives**—A legal document an adult can use to direct in advance the decisions about his or her mental and/or physical health treatment, if in the future he/she lacks the capacity to make his/her own health care decisions. Two types of advance directives related to mental health treatment are: a "Declaration for Mental Health Treatment" subject to the requirements of Chapter 2135 of the Revised Code, and a "Durable Power of Attorney for Health Care" subject to the requirements of sections 1337.11 to 1337.17 of the Revised Code.
(2) **Behavior Management**—The utilization of interventions that are applied in a systematic and contingent manner in the context of individual or group programs to change or manage behavior or facilitate improved self-control. The goal of behavior management is not to curtail or circumvent an individual's rights or human dignity, but rather to support the individual's recovery and increase his/her ability to exercise those rights.
(3) **Comfort Rooms**—(formerly known as quiet or time-out rooms) Adapted sensory rooms that provide sanctuary from stress and/or can be places for persons to experience feelings within acceptable boundaries. **Sensory Rooms**—Appealing physical spaces painted with soft colors with the availability of furnishings and objects that promote relaxation and/or stimulation.
(4) **Individual Crisis Plan**—A written plan that allows the person to identify coping techniques and share with staff what is helpful in assisting to regain control of his/her behavior in the early stages of a crisis situation. It may also be referred to as a "behavior support plan."
(5) **Mechanical Restraint**—Any method of restricting a person's freedom of movement, physical activity, or normal use of his or her body, using an appliance or device manufactured for this purpose.
(6) **Physical Restraint**—Also known as "manual restraint." Any method of physically restricting a person's freedom of movement, physical activity, or normal use of his or her body without the use of mechanical restraint devices.
(7) **PRN (pro re nata)**—As the situation demands.
(8) **Prone Restraint**—All items or measures used to limit or control the movement or normal functioning of any portion, or all, of an individual's body while the individual is in a face-down position for an extended period of time. Prone restraint may include either physical (also known as manual) or mechanical restraint.
(9) **Seclusion**—The involuntary confinement of a person alone in a room where the person is physically prevented from leaving.
(10) **Time-out**—An intervention in which a person is required to remove him/herself from positive reinforcement to a specified place for a specified period of time. Time-out is not seclusion.
(11) **Transitional Hold**—A brief physical (also known as manual) restraint of an individual face-down for the purpose of quickly and effectively gaining physical control of that individual, or prior to transport to enable the individual to be transported safely.

5122-26-16 (D) General Requirements	Correlation With *Nonviolent Crisis Intervention*® Training
(1) Seclusion or restraint shall not be used unless it is in response to a crisis situation, i.e., where there exists an imminent risk of physical harm to the individual or others, and no other safe and effective intervention is identified. (a) They shall not be used as behavior management interventions, to compensate for the lack of sufficient staff, as a substitute for treatment, or as an act of punishment or retaliation. (b) Absent a co-existing crisis situation that includes the imminent risk of physical harm to the individual or others, the destruction of property by an individual, in and of itself, is not adequate grounds for the utilization of these methods.	CPI's *Nonviolent Crisis Intervention*® training is grounded in a philosophy of *Care, Welfare, Safety and Security*SM for all staff and students; therefore, we support that restraint should be used only as a last resort when an individual presents an imminent risk of physical harm to self or others and when less restrictive interventions have been tried and have failed. Additionally, 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. Restraint should never be used as compensation for a lack of sufficient staff, as a substitute for treatment, as punishment, or as retaliation. Furthermore, CPI supports that physical restraint or seclusion should not be utilized for property destruction unless that behavior co-exists with an imminent risk of physical harm to the individual or others.
(2) The following shall not be used under any circumstances: (a) Behavior management interventions that employ unpleasant or aversive stimuli such as: the contingent loss of the regular meal, the contingent loss of bed, and the contingent use of unpleasant substances or stimuli such as bitter tastes, bad smells, splashing with cold water, and loud, annoying noises. (b) Any technique that restricts the individual's ability to communicate, including consideration given to the communication needs of individuals who are deaf or hard of hearing; (c) Any technique that obstructs vision; (d) Any technique that obstructs the airways or impairs breathing; (e) Use of mechanical restraint on individuals under age eighteen; (f) A drug or medication that is used as a restraint to control behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's medical or psychiatric condition or that reduces the individual's ability to effectively or appropriately interact with the world around him/her; and (g) The use of handcuffs or weapons such as pepper spray, mace, nightsticks, or electronic restraint devices such as stun guns and Tasers.	The physical restraints taught in the *Nonviolent Crisis Intervention*® training program are designed for safety and allow for a Therapeutic Rapport to be re-established with the individual who has lost control. Key elements of the interventions include: ▪ No element of pain is involved. ▪ The intent is to calm the individual. ▪ The intent is to keep the individual off the floor, thus reducing the risks of restraint-related positional asphyxia and other injuries. ▪ Team interventions are used when necessary. ▪ Interventions are used only as a last resort when someone presents a danger. ▪ Interventions are used to protect—not to punish.

5122-26-16 (D) General Requirements	Correlation With *Nonviolent Crisis Intervention*® Training
(3) Position in physical or mechanical restraint. (a) An individual shall be placed in a position that allows airway access and does not compromise respiration. (i) The use of prone restraint is prohibited. (ii) A transitional hold shall be limited to the minimum amount of time necessary to safely bring the person under control, at which time staff shall either terminate the transitional hold, and begin the post-restrain process required by this rule, or, if the individual cannot safely be released from the transitional hold, re-position the individual into an alternate restraint position.	CPI acknowledges that some restraint positions are more dangerous than others. Therefore, CPI's *Nonviolent Crisis Intervention*® program teaches only standing restraint positions. While we support the prohibition of prone restraint, we also support the Department's position on allowing a transitional hold to be utilized in emergency situations in which a restraint either goes to the ground or begins on the ground. CPI addresses this very emergency within our *Applied Physical Training*SM program—in which we teach a transitional hold. The Emergency Floor Procedures taught within this program are designed to be utilized to gain control of an individual who drops to the floor or injures himself on the floor and staff determine that disengaging is not an option. Because the floor is a dangerous place to be when restraining someone, the use of a transitional hold should always be viewed as an interim position with the goal being to return the individual to a safer standing position as soon as possible.
(b) The use of transitional hold shall be subject to the following requirements: (i) Applied only by staff who have current training on the safe use of transitional hold techniques, including how to recognize and respond to signs of distress in the individual.	CPI's *Applied Physical Training*SM program is open only to active Certified Instructors of the *Nonviolent Crisis Intervention*® training program. To be authorized to deliver content from this program within their bases of employment, Instructors must attend, demonstrate competency in, and successfully complete a three-day advanced program taught by CPI.
(ii) The weight of the staff shall be placed to the side, rather than on top of the individual. No transitional hold shall allow staff to straddle or bear weight on the individual's torso while applying the restraint, i.e. no downward pressure may be applied that may compromise the individual's ability to breathe.	CPI recommends that once Instructors are authorized to deliver the curriculum, they conduct formal refreshers (in a minimum of six hours) in which they teach and test staff on the use of a transitional hold. All transitional holds (Emergency Floor Procedures) in this program meet the criteria outlined in this section: there is no downward pressure to the individual, no straddling of the individual's torso, no weight bearing on the individual's torso, no use of a soft device to cushion the individual's head, and the arms of the individual are not under or behind the individual's head or body.
(iii) No transitional hold shall allow the individual's hands or arms to be under or behind his/her head or body. The arms must be at the individual's side.	
(iv) No soft device, such as a pillow, blanket or other item, shall be used to cushion the client's head, since such a device may restrict the individual's ability to breathe.	
(v) All staff involved in the procedure must constantly observe the individual's respiration, coloring, and other signs of distress, listen for the individual's complaints of breathing problems, and immediately respond to ensure safety.	In all its curriculums, CPI teaches that all use of physical restraint should be monitored continuously with the goal being to disengage or end the intervention at the earliest possible moment once the person is no longer a danger to self or others, or at the first sign of distress. The importance of monitoring for signs of distress is emphasized within the curriculum.

5122-26-16 (D) General Requirements	Correlation With *Nonviolent Crisis Intervention*® Training
(6) Following the conclusion of each incident of seclusion or restraint, the client and staff shall participate in a debriefing(s). (a) The debriefing shall occur within twenty-four hours of the incident unless the client refuses, is unavailable, or there is a documented clinical contraindication. (b) The following shall be invited to participate unless such participation is clinically contraindicated and the rationale is documented in the clinical record: (i) for each child/adolescent client, the family, or custodian or guardian, or (ii) For an adult client, the client's family or significant other when the client has given consent in accordance with (D)(4)(a) of this rule, or an adult client's guardian, if applicable. (7) A thorough review and analysis of each incident of the use of seclusion or restraint shall be undertaken in order to use the knowledge gained from such analysis to inform policy, procedures, and practices to avoid repeated use in the future and to improve treatment outcomes. Secondarily, such analysis should help to mitigate, to the extent possible, the adverse and potentially traumatizing effects of a seclusion or restraint event for involved staff, clients, and for all witnesses to the event.	A consistent variable in all instances of successful restraint and seclusion reduction (or elimination) is mandatory client and staff debriefing. In *Nonviolent Crisis Intervention*® training, CPI offers a model for debriefing that can be utilized with both clients and the staff that were involved, or with any bystanders or witnesses to the event. This Postvention process creates a learning opportunity for everyone. It enables clients and others involved in the crisis to express their views on the situation and to create a plan for preventing the acting-out behavior in the future by identifying the precipitants 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 precipitants 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.
5122-26-16 (F) Staff Training	**Correlation With *Nonviolent Crisis Intervention*® Training**
(1) The agency shall ensure that all direct care staff and any other staff involved in the use of seclusion or restraint receive initial and annual training designed to minimize their use. (a) Staff shall be trained in and demonstrate competency in the correct and appropriate use of non-physical techniques for intervention, such as mediation and conflict resolution, and de-escalation of disruptive or aggressive acts, person and/or situations: and (b) Staff shall be trained in understanding how their behavior can affect the behavior of clients.	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. CPI further expands verbal de-escalation strategies to cover a wide array of defensive behaviors including questioning, refusal, venting, making threats, and presenting intimidation and other forms of noncompliance. Strategies such as limit setting and Empathic Listening are discussed throughout the curriculum. Also addressed throughout the curriculum, specifically in Unit I and Unit V, is the concept of the Integrated Experience, how the behaviors and attitudes of staff affect the behaviors and attitudes of individuals in their care, and vice versa. Staff are taught how to manage their own anger while maintaining their professionalism at all times.

5122-26-16 (F) Staff Training	Correlation With *Nonviolent Crisis Intervention*® Training
(2) The agency shall identify, educate and approve staff members to use seclusion or restraint. Competency of staff in the use and documentation of seclusion or restraint methods shall be routinely evaluated. The results of the evaluations shall be maintained by the agency for a minimum of three years for each staff member identified. (a) Staff shall have appropriate training prior to utilizing seclusion or restraint, and, at a minimum, annually thereafter. (i) Staff shall be trained in and demonstrate competency in the identification and assessment of those possible risk factors identified in paragraph (G) of this rule and to understand how these may impact the way a client responds to seclusion or restraint, and place an individual at greater risk to experience physical or psychological trauma during an episode of seclusion or restraint;	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.
(ii) Staff shall be trained in and demonstrate competency in choosing the least restrictive intervention based on an individualized assessment of the client's behavioral and/or medical status or condition;	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.
(iii) Staff shall be trained in and demonstrate competency in the safe application of all seclusion or restraint interventions he or she is authorized to perform, including specific training in utilization of transitional hold, if applicable; (iv) Staff shall be trained and certified in first aid and CPR; (v) Staff shall be trained in and demonstrate competency in recognizing and responding to signs of physical distress in clients who are being secluded or restrained;	Every Participant Workbook includes information on the risks of restraint use, as well as information on reducing the risks associated with restraint and seclusion use. Additionally, the Instructor Manual includes further information on monitoring for signs of distress. This information, along with the lecture on crisis response team duties, equips staff with the information necessary for monitoring for signs of distress in a restrained or secluded individual.
(viii) Staff shall be trained in and demonstrate competency in helping a client regain control to meet behavioral criteria to discontinue seclusion or restraint. (b) Leadership shall maintain a current list of staff authorized to utilize seclusion or restraint interventions which is readily available to all agency staff who may be asked to participate in these interventions; and (c) The curriculum used to train staff shall be documented and shall be made available to ODMH upon request.	The units on physical intervention emphasize the goal of continually assessing the individual for signs of Tension Reduction, or a return to rationality. Assessing individuals for signs of Tension Reduction enables staff to discontinue the seclusion or restraint at the earliest possible moment as soon as the individual in crisis is no longer an immediate danger to self or others. At the completion of each training event, Certified Instructors can document their training online. CPI's online documentation system allows Certified Instructors to maintain accurate and detailed records of all training events.