SENATE BILL 325 REPORT

Reduction of Restraint and Seclusion Practices in Behavioral Health Emergencies Progress Report

Submitted to the Texas Legislature

As Required By
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79th Legislature, Regular Session, 2005

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Table of Contents

Executive Summary

Senate Bill 325, 79th Legislature, Regular Session, 2005, outlined requirements for certain facilities and programs that utilize restraint and seclusion for behavior management of facility residents. The legislation also required the Texas Health and Human Services Commission (HHSC) to establish a work group to review and provide recommendations regarding best practices in policy, training, safety, and risk management to govern the management of facility residents' behavior related to restraint and seclusion practices.

Senate Bill 325 required that the work group include members representing the Department of State Health Services (DSHS), the Department of Aging and Disability Services (DADS), the Department of Family and Protective Services (DFPS), the Texas Youth Commission (TYC), the Texas Education Agency (TEA), the Texas Juvenile Probation Commission (TJPC), and Advocacy, Inc. Additional members were also required as recognized experts or to represent the interests of facility residents, including advocates, family members, physicians, representatives of hospitals, social workers, and psychiatric nurses.

The work group convened to study and make recommendations on: (1) developing a comprehensive reporting system for the collection and analysis of data related to behavior management interventions; (2) the prevention of death or serious injury to facility residents related to physical intervention or restraint; (3) de-escalation techniques and minimum standards to manage the behavior of residents in an emergency situation; (4) best practices for physical, behavioral, and de-escalation interventions; (5) best practices related to specific populations; and (6) best practices related to use of seclusion with facility residents.

Two reports were required by S.B. 325 to submit to the Legislature. The first was provided in September, 2006 and described the work group's recommended best practices. Appendix A provides the list of recommendations included in the first report. This second report describes actions taken by agencies to implement the best practices recommended by the work group in the first report. Part 1 reports on the rule changes that were adopted, as required by S.B. 325. Senate Bill 325 mandated the adoption of rules governing several aspects of the use of restraint and seclusion for agencies under the jurisdiction of the Executive Commissioner of the Health and Human Services Commission including DADS, DSHS, and DFPS. The required rule changes were adopted and went into effect on or before June 1, 2006.

Part II provides information on the agencies' progress on implementing recommendations as well as other initiatives related to reducing and minimizing risk in restraint and seclusion practices. All agencies have reported progress in addressing the recommendations. Part III describes challenges reported by agencies with regard to implementation of the recommendations. Most agencies reported that the challenges they face in implementing the recommendations of the work group involve rule changes and potential funding considerations. Appendix B provides the agencies' templates that were submitted to complete this report.

Part I
Senate Bill 325 Rules Implementation

Senate Bill 325 required the adoption of rules governing several aspects of the use of restraint and seclusion for health and human services agencies, including DADS, DSHS, and DFPS. The rule changes went into effect on or before June 1, 2006 and provided the following:

(1) Prohibits certain restraints including a restraint: That obstructs the resident's airway, including any procedure that places anything in, on, or over the resident's mouth or nose; impairs the resident's breathing by putting pressure on the torso; or interferes with the resident's ability to communicate.

(2) Permits the use of a prone or supine hold on the resident of a facility only if the person limits the hold to no longer than the period specified by rules adopted in accordance with 3, 4, 5, 6 below and:

- uses the hold only as a last resort when other less restrictive interventions have proven to be ineffective; and
- uses the hold only when an observer, who is trained to identify the risks, associated with positional, compression, or restraint asphyxiation and with prone and supine holds and who is not involved in the restraint, is ensuring the resident's breathing is not impaired. (Note: small residential service providers are exempt from the observer provision.)

(3) Defines acceptable restraint holds that minimize the risk of harm to a facility resident.

(4) Governs the use of seclusion of facility residents.

(5) Develops practices to decrease the frequency of the use of restraint and seclusion.

(6) Permits prone and supine holds only as transitional holds for use on a resident of a facility.

(7) Requires that each resident at a facility regulated by a health and human service agency and the resident’s legally authorized representative are notified of the rules and policies related to restraint and seclusion.

(8) Prohibits retaliation against an employee, client resident, or other person because the employee, client, resident, or other person files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility; or a client or resident of the facility because someone on behalf of the client or resident files a complaint, presents a grievance, or otherwise provides in good faith information relating to the misuse of restraint or seclusion at the facility.

Additionally, S.B. 325 stipulated that a facility may adopt procedures for the facility's use

of restraint and seclusion practices that are more restrictive than is required by a rule of the regulating health and human services agency.

As required by S.B. 325, all health and human service agencies impacted by the legislation have adopted rules or have demonstrated that the existing rules sufficiently covered the requirements of S.B. 325.

Department of Family and Protective Services (§§ 720.1003, 720.1007 and 720.1012)

As of March 1, 2006, amendments were made that:

- Provide general restraint prohibitions (e.g., prohibiting restraint that obstructs the child's airway).
- Specify limitations on prone and supine restraints.
- Prohibit retaliation.
- Require training on the risks associated with prone and supine restraints.

Additional rules were adopted by DFPS related to emergency behavioral intervention that:

- Require facilities to obtain at admission each child's input on preferred de-escalation techniques and revisiting this information after each emergency behavioral intervention.
- Increase pre-service and annual training for caregivers and administrators related to emergency behavioral interventions.
- Increase emphasis on restraint risks and appropriate monitoring of restraints in the emergency behavioral intervention training curriculum.
- Provide more specificity regarding time limits and requirements when a child must be released from an emergency behavioral intervention.
- Increase data collection and overall evaluation requirements related to emergency behavioral interventions, including quarterly data reporting to DFPS.

Department of Aging and Disability Services

DADS is responsible for the regulation of several categories of programs/facilities that are affected by the requirements of S.B. 325 including Intermediate Care Facilities for Persons with Mental Retardation (ICFs/MR), Home and Community-Based (HCS) Waiver Program, Nursing Facilities and Assisted Living Facilities (ALFs). As of June 1, 2006, DADS adopted rules governing the facilities.

Intermediate Care Facilities for Persons with Mental Retardation (40 TAC §§ 90.3, 90.42 and 90.328)

Amendments were made that:

- Define acceptable restraint holds that minimize risk of harm to a resident (referred to as "personal holds" in the adopted rules).

- Develop practices to decrease the frequency of the use of restraint.
- Require a facility to notify the resident and the resident's legally authorized representative (LAR) of the rules and policies related to restraint and seclusion.
- Prohibit facility retaliation when someone files a complaint or grievance relating to the facility's misuse of restraint or seclusion.
- Allow a facility to adopt policies that promote less use of restraint than allowed by the rules of the chapter.

Home and Community-based Waiver Program (40 TAC §§ 9.153, 9.173(b)(4), 9.177(c)(1), 9.178(f)(5), 9.178(j) and new rules §§ 9.178(k) and 9.179)

Amendments were made that:

- Include provider requirements regarding the use of restraint and notification.
- Address provider requirements regarding staff training.
- Require providers to report "critical incident" data, including restraint.

Although Health and Safety Code, §322.055 only requires compliance by providers of supervised living and residential support in the HCS Program, DADS elected to apply the requirements to all HCS Program providers.

Nursing Facilities (40 TAC §19.601 and §19.408)

Amendments were made that:

- Define acceptable restraint holds.
- Develop practices to decrease the frequency of the use of restraint and seclusion.
- Ensure that each resident and the resident's LAR are notified of the rules and policies related to restraints and seclusion.
- Prohibit a restraint that places a resident in a prone and supine hold under any circumstance.
- Prohibit a facility from retaliating against a person because the person in good faith provides information relating to the misuse of restraint or seclusion at the facility or against a resident.

Assisted Living Facilities (40 TAC §§ 92.3, 92.41 and 92.559)

Amendments were made that:

- Develop practices to decrease the frequency of the use of restraint.
- Require the facility to notify the resident and the resident's LAR of the rules and policies related to restraint and seclusion.
- Prohibit facility retaliation when someone files a complaint or grievance relating to the facility's misuse of restraint or seclusion.

Department of State Health Services

DSHS is responsible for the regulation of several categories of programs/facilities that are affected by the requirements of S.B. 325 including Private Psychiatric Hospitals and Crisis Stabilization Units, Hospitals, Chemical Dependency Treatment Facilities, and Intervention in Mental Health Programs. Rules currently in place for all facilities except Chemical Dependency Treatment Facilities either met or exceeded the requirements provided in S.B. 325.

Chemical Dependency Treatment Facilities (25 Texas Administrative Code §§448.603(d)(5); 448.701(a); 448.706)

Effective June 1, 2006 DSHS rules:

- Add requirements to the restraint and/or seclusion training program.
- Clarify the responsibility of treatment facilities to implement and enforce client rights, including the responsibility of the facility to notify the client and the client's LAR of the rules and policies related to restraint and seclusion, and the requirement, in conjunction with 25 TAC § 448.802(b), that they be so notified.
- Define a small residential facility that is not subject to the new requirement for a non-participant observer to be present when a prone or supine hold is used.
- Define practices to promote the safe, limited, and appropriate use of restraint and seclusion in chemical dependency treatment facilities.
- Govern the use of a prone or supine hold.
- Add restrictions and safeguards relating to restraint and seclusion to reduce their frequency and minimize the risk of harm.
- Require certain actions after an episode of restraint or seclusion to help reduce the frequency and increase the safety of any future use of restraint or seclusion.

To avoid conflict with Health and Safety Code § 322.052(c), language requiring the authorization of personal restraint in certain facilities was removed from the rule, without preventing or discouraging facilities from retaining authorization, if needed, for the use of personal restraints consistent with the law.

The rule changes that were required by June 1, 2006 were only applicable to the health and human services agencies. However, both the TYC and the TJPC provided information regarding their rules that currently fit the parameters of the rules referenced in the above section or the possibilities for modification that would provide parallels to the newly adopted rules mandated under S.B. 325.

Texas Juvenile Probation Commission

Effective September 2003, the TJPC adopted rules that specifically address the majority of rules enumerated in Subchapter B of S.B. 325. These are currently found in TAC, Title 37, Chapter 343, Subchapter E, and Sections 343.60 through 343.65 and TJPC's current standards indirectly incorporate S.B. 325's rule 322.051(b)(3), which requires a trained "observer" to be

present during a prone or supine restraint to monitor the restrained subject's breathing status. Specifically, the TJPC's standards prohibit, "any restraint technique that does not require the monitoring of the resident's respiration and other signs of physical distress during the restraint.…" However, such monitoring does not have to be conducted by a non-involved observer.

Senate Bill 325 rules that are not specifically included in the TJPC's standards are the provisions preventing retaliation against reporting the misuse of a restraint or seclusion practice. Instead under TJPC standards, retaliation is prohibited if the misuse rises to the level of an allegation of abuse or neglect.

Regarding the provisions that allow a health and human services agency to revoke a facility license, the TJPC may impose a quasi-administrative sanction against a facility by modifying its financial assistance contract with a jurisdiction, but a facility's "certification" status rests solely with the authority vested in the local juvenile board (per the Texas Family Code).

Areas of the TJPC standards that do not currently harmonize with the specific language of the S.B. 325 and/or the workgroup report recommendations are currently being evaluated for a public comment review period anticipated to start in May 2007, with proposed revisions scheduled to go into effect on September 2009. Of specific interest during this review period will be standards and terminology specific to seclusion practices.

Texas Youth Commission

As of March 3, 2005, TYC General Administrative Policy (GAP) 97.23 Rule: Use of Force, was rewritten to provide greater consistency and clarify when force is to be used and what steps should be taken to prevent the need for it. No substantive changes were made.

Part II
Agency Progress on Recommendations and Other Initiatives

The following information was provided by health and human services agencies, TJPC, and TYC on progress of implementation of recommendations provided in the first S.B. 325 report (see Appendix A). Agencies have also provided information regarding other initiatives that have been implemented in an effort to reduce the use of restraint and seclusion as an emergency behavioral intervention.

Department of Family and Protective Services

In anticipation of several of the S.B. 325 workgroup recommendations, as well as internal initiatives, DFPS developed several new rules and contracting requirements that went into effect January 1, 2007. These included requirements for regulated facilities to report quarterly the aggregate numbers of personal restraints, mechanical restraints, seclusions, and incidents in which emergency medication was administered.

In addition, new DFPS standards for residential child-care went into effect in January 2007. These require:

- Each operation to obtain at admission each child's input on preferred de-escalation techniques and revisiting this information after each emergency behavior intervention.
- Increased pre-service and annual training for caregivers and administrators related to emergency behavioral intervention.
- Increased emphasis on restraint risks and appropriate monitoring of restraints in the emergency behavior intervention training curriculum.
- More specificity regarding time limits and requirements regarding when a child must be released from emergency behavior intervention.
- Increased data collection and overall evaluation requirements related to emergency behavior intervention, including quarterly data reporting to DFPS.

Regarding recommendations to require regulated facilities to employ competency-based training, DFPS reviews and approves emergency behavior intervention policies and training for compliance with licensing standards at the point of a facility's application to be licensed, which details the required training curriculum and standards, including a requirement that the training be competency-based. In addition, facility policies are required to include a description of the training curriculum and facilities must notify DFPS if their policies change. DFPS also requires each facility to annually re-evaluate the effectiveness of their emergency behavioral intervention programs, including policies and training curriculum.

Further, DFPS has recently reviewed and revised its licensing standards for residential child care, which "raise the bar" and not only increase regulations around the use of emergency behavior interventions, but strengthen the quality of residential care overall. This is intended to reduce the use of restraint and seclusion by improving the quality of staff, the child-to-staff ratios, the quality of admissions, service planning, and discharge information.

Department of Aging and Disability Services

DADS pursues policies and practices that aim to reduce the use of restraint and seclusion in their regulated facilities. These efforts include initiating a number of research efforts as well as ongoing evaluation exercises- all aimed at improving responses to behavioral emergencies.

With regard to S.B. 325 work group recommendation to implement competency-based staff training, current rules at 40 TAC § 92.41(a)(4)(B)-(D), regulating assisted living facilities (ALFs) and state mental retardation (MR) facilities (§ 5.363) require competency-based staff training appropriate to responsibility and position. DADS also recently initiated the rulemaking process to amend rules for Assisted Living Facilities to include requirements for persons who are authorized to perform a restraint.

In 2004, DADS adopted rules that govern the use of restraint and behavior therapy in state mental retardation facilities, which are state-operated ICFs/MR. These include provisions that address the requirements of S.B. 325 and are consistent with subsequent amendments to the ICF/MR program rules. The state MR facility rules require facilities to:

- Assess an individual upon admission for contraindications to the use of restraint, followed by an annual reassessment.
- Provide reports to the head of the facility and state office and to the DFPS in the event of death or injury related to the use of restraint.
- Provide training appropriate to the position and responsibilities of staff.

DADS has implemented efforts to collect additional information regarding best practices, consensus thinking, and promising practices related to the populations served in DADS programs. DADS currently has a contract with Texas A&M University to conduct a systematic literature review (SLR) across the following topics:

- Use of Incident Reporting in Programs for People with Developmental Disabilities. For this review, “incident” is any actual or alleged event or situation that creates a significant risk of substantial or serous harm to the physical or mental health, safety, or well being of a participant. Examples include, but are not limited to, the use of restraints to control behaviors.
- Managing Maladaptive Behaviors in People with Developmental Disabilities. For this review, “maladaptive behaviors” refers to any self-injurious, verbally aggressive, or physically violent behaviors that impact a person’s quality of life, or those around the person.

DADS requested that Texas A&M incorporate the Reference and Resource List (Appendix C of the S.B. 325 report compiled by HHSC, September 2006) into this initiative. Research findings will be evaluated for application to all of DADS programs. When best practices are identified, DADS will work with stakeholders to determine the most effective means by which to encourage implementation by providers.

DADS has started a number of efforts aimed at reducing the use of restraint and seclusion interventions. For example, in state facilities, the possible need for restraint has been identified across a variety of circumstances, including medical/dental procedures, postural support, protection, and behavior management. Facility staff records each restraint occurrence and make distinctions in the level of intrusiveness; and between emergency use and planned use. For all restraint episodes, information regarding frequency, duration, location, etc., is entered into an automated system. Each restraint occurrence is evaluated by the facility and analyzed for lack of progress with the goal of minimizing restraint use. Efforts to minimize restraint use are ongoing, even as there is an increase in admissions of individuals who are behaviorally challenged.

Restraint reduction is also being pursued through other means such as new employee orientation. Staff receives training in the principles of Positive Behavior Support and the prevention of aggressive behavior. This training and the philosophy behind it are reinforced through subsequent training in individual behavior support plans, which are designed to support positive and less intrusive interventions than restraint. In addition, staff is trained to recognize the importance of active treatment and ensuring that residents are engaged in activities that are meaningful to their overall benefit and development. The concept of keeping people meaningfully engaged and treating them with respect and support is central to any successful restraint reduction effort. Facility staff has incorporated this philosophy into day-to-day operations.

Another recent initiative included the development of a comprehensive data resource, through a recently completed 2003 Real Choice Systems Change Grant. Consultants designed a quality assurance and improvement data warehouse that will produce standardized reports, as well as provide capability for ad-hoc reporting. The areas covered by the reports will include consumer demographics, service utilization, enrollments, levels of care, plans of care, consumer-directed options, critical incidents, abuse, neglect, and exploitation, provider compliance and oversight, transfers, discharges, complaints, and recoupments. This will provide DADS, and eventually stakeholders, the mechanism to identify trends and areas for improvement, including restraint and seclusion.

The implementation of Senate Bill 52, 79th Legislature, Regular Session, has provided DADS with the opportunity to issue a competitive grant program for aging and disability services. Specifically, DADS will issue two Requests for Proposals for the purpose of enhancing quality in the provision of long-term services and supports:

- Innovative Best Practice Knowledge Dissemination on selected topics, including but not limited to restraint reduction. This award would provide funding to entities able to demonstrate an innovative practice in long term services and supports in the identified areas. The funds would support activities or events that showcase the tools, techniques and methodologies used to achieve positive outcomes for individuals receiving services.

- Test Innovative Practices in Service Provision. This award would support a project to test a strategy for improving some aspect of the long term service delivery system. The contract

would require an entity to conduct an innovative service delivery model or method that would be evaluated for effectiveness in collaboration with an academic institution.

Based on DADS experience in providing technical assistance to reduce restraints for posturing and falls in nursing facilities, the agency will explore the feasibility of expanding the provision of technical assistance to other programs and the reduction of restraint related to a behavioral emergency. This will entail reviewing the strategies that have been used successfully in state facilities to determine if those can be replicated in community ICFs/MR.

Department of State Health Services

DSHS has been actively pursuing mechanisms to curb the use of restraint and seclusion in their regulated facilities. One of these efforts involved participation in Hogg Foundation workshops and training in both 2004 and 2006. These workshops have served to create increased awareness of the need to reduce or even eliminate the use of restraint and seclusion. The 2006 Hogg Foundation Training Institute was planned to be held in collaboration with the National Association of State Mental Health Program Directors (NASMHPD) National Technical Assistance Center, which had previously designed a comprehensive training program to assist organizations and state systems with restraint and seclusion reduction. All Texas State Hospitals participated, as well as private hospitals, state schools, and residential programs throughout the state. Currently, all state hospitals have developed plans aimed at reducing the use of restraint and seclusion.

Another initiative involved the appointment of a 15-member State Hospitals Section Restraint and Seclusion Reduction Workgroup for the purpose of developing strategies and recommendations that would lead to a reduction in the use of restraint and seclusion. The group began by focusing on restraint and seclusion data currently gathered in the system followed by a review of prevailing rules and laws related to restraint and seclusion use. Early in the process, the group realized that in order for the system to move beyond the point at which its efforts to reduce these restrictive interventions had reached a plateau; the culture in hospital treatment environment had to change. A survey instrument designed by David Colton, PhD., Check list for Assessing Your Organization's Readiness for Reducing Seclusion and Restraint, was utilized to survey almost 1,000 hospital employees. These data are being used as hospitals develop plans for reduction. The Committee has also focused on the identification and scoring of restraint and seclusion events with assistance of Dr. Lucille Schacht, Director of Operations and Statistical Analysis of the National Association of State Mental Health Program Directors (NASMHPD) Research Institute. This has resulted in standards for reporting that have been approved for the hospital system. The Committee will also review all the hospital plans for reduction.

In the 1999, Third Edition of *Prevention and Management of Aggressive Behavior (PMAB®)*, the Texas Department of Mental Retardation Human Resources Department (now Facility Support Services-Competency Training and Development Training Specialists at HHSC) made the following changes to the PMAB® training materials:

- PMAB® 1.0 (Overview) – Content was added as well as an activity on observing behavior and early intervention.

- PMAB® 1.0 – Four characteristics were added (i.e. prevention is emphasized, pain is avoided, minimum energy is applied, and both employee and person served are protected) to the content and those characteristics were incorporated into other sections of PMAB®.

- PMAB® 2.0 (Communication) – Information on communication skills was expanded for persons with Mental Retardation and more population-specific case studies for classroom practice and competency assessment were developed.

In 2000-2003, in response to anticipated reorganization of the health and human services agencies, the Restraint and Seclusion course was divided into two population-specific curricula, one for the mental health population of state hospitals in DSHS and one for the mental retardation population of state schools in DADS. Since 2000, HHSC facility support services-competency training and development training specialists continue to review and evaluate other available crisis intervention programs to identify if safe or more effective procedures or training materials exist. Currently, information to expand the communications section for the training program is being researched.

Finally, FY 2007 Substance Abuse contractors are bound by general provisions that include a requirement in Section 21.04 for treatment facility contractors to adopt a policy either authorizing or prohibiting restraint and seclusion. The general provision states that if the contractor is authorized to use restraint and seclusion, it must comply with 25 TAC Chapter 448.706 and train all direct care staff in residential programs and in programs accepting court commitments on restraint and seclusion in accordance with § 448,603(d)(5).

Texas Juvenile Probation Commission

The TJPC has recently launched discussions related to incentive programs or the replication or modeling of programs which have minimized the use of seclusion and restraint practice. Specifically:

- Staff from the TJPC and three local jurisdictions (Bexar, El Paso, and Randall counties) recently participated in the Hogg Foundation-sponsored conference entitled, Creating Violence Free Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint. The TJPC intends to include these three jurisdictions in a technical assistance consortium to assist other jurisdictions in their assessment of their restraint and seclusion reduction efforts. It is hoped that this peer modeling concept will be more

effective in changing facility specific restraint and seclusion cultures than simple rule compliance directives.
- Additionally, the TJPC is going to make a concerted effort to publicly (e.g., agency newsletter, etc.) recognize jurisdictions that have made significant reductions in the use of restraints and seclusion.

Currently, the TJPC requires that all facilities under its regulatory authority utilize a personal restraint technique, which requires a formalized certification process that is competency based. Related to the S.B. 325 workgroup recommendation concerning competency-based staff training, the TJPC has already initiated and is near completion (anticipated completion in January 2007) of a formalized personal restraint curriculum review process that helps ensure the competency-based component of each curriculum being used.

The TJPC hosted a facility specific conference in the September 2005 that was designed to highlight some of the most topical concerns in today's juvenile corrections arena. Central in this conference's agenda were restraint specific topics, and to a lesser degree, seclusion practices. This conference had the highest caliber speakers and had state-wide and some out-of-state participants.

Additionally, the TJPC's Abuse, Neglect and Exploitation Investigations Unit requires the reporting of "serious incidents" occurring in facilities. These serious incidents are often associated with improper physical and mechanical restraint applications. When such incidents are also deemed to be incidents of abuse or neglect, they are actively investigated with the goal of identifying the inappropriate staff behaviors and sanctioning staff who are subsequently designated as being perpetrators of abuse or neglect.

Texas Youth Commission

With respect to S.B. 325 recommendations, TYC indicated that facility residents are currently assessed by a psychologist to determine the youth's motivation for the aggressive behavior and to recommend program and staff interventions necessary for youth to develop internal behavioral controls. The agency employs several behavioral management treatment plans enumerated in GAP 97.16 related to Primary Intervention Program and GAP 95.17 related to Behavioral Management Program. TYC requires standardized intake information on every youth committed to the agency. Intake assessment includes the delinquent history, family/developmental history, initial behavioral adjustment in TYC, and various additional assessments (e.g., medical, educational, psychiatric). A forensic psychological evaluation is also conducted to assess the juvenile's history and prior aggression and to render treatment recommendations. These efforts aid clinical and direct care staff in developing individualized case plans and behavioral intervention plans.

As part of its current operations, TYC conducts pilot/ field tests training and tracks performance indicators to measure the effectiveness of training programs. Additionally, current training programs are presented for approval at by executive personnel and agency training is monitored through performance indicators.

In response to the recommendation requiring competency-based training, TYC indicates that their physical restraint training is currently conducted in a competency based framework. The agency is field testing enhanced competency based training on de-escalation communications skills, behavioral management intervention, and on-the job-training. Enhanced training will expand the staff competencies on progressive de-escalation interventions to reduce the use of physical restraint. Consistent with the recommendation to field-test best practices, training enhancements are piloted/ field tested prior to agency implementation. In addition, physical restraint training has also been enhanced consistent with adopted policy on Use of Force, GAP 97.23.

TYC is clarifying a policy which will emphasize the use of force as a last resort and has recently developed competency based new employee training enhancements to expand staff competencies in de-escalation methods and behavioral interventions. In addition,
TYC is currently field testing de-escalation training enhancements; enhanced behavior management (group intervention) training; and implementing a system for post-physical restraint processing to address medical and psychological impact on youth subsequent to physical restraint. Other efforts include developing a comprehensive management information system for trend analysis of youth grievances, which include alleged mistreatment, investigations of physical restraints, and enhancements to the quality assurance monitoring systems.

Finally, with the goal of reducing the use of restraint and seclusion, TYC has submitted a Legislative Appropriations Request (LAR) Exceptional Items Request to improve direct case and case manager ratios to improve supervision and rehabilitative outcomes as well as an LAR Exceptional Item request to improve training for direct care and professional staff.

Part III
Challenges to Implementation

The following information was provided by the agency work group members that are viewed as challenges to implementing the recommendations in the first S.B. 325 Report (see Appendix A for a list of the recommendations). The work group was required to identify best practices. In some instances, best practices may require additional resources to implement fully. To fully address the recommendations formulated by the workgroup may require additional resources for agencies and/or providers.

Department of Family and Protective Services

With respect to required rule changes, DFPS has indicated that they will have to pass new or modify existing rules in order to fully implement some of the recommendations in the S.B. 325 report.

While some applicable rules changes are anticipated in January 2007, other components of the reporting requirements stipulated in Recommendation #1, would require further rule modification. Of special note, with regard to reporting by facility type, due to changes in classification of facility types which will be effective on January 1, 2007, DFPS will no longer be able to report data specific to children receiving treatment services for mental retardation – as would have been the case prior to the reclassifying effort. This is noted to ensure that the requirement relative to reporting by facility type recognizes the newly classified facility types.

Further, DFPS does not currently distinguish between voluntary and involuntary emergency medications, which would require further rule revisions. While DFPS rules currently require facilities to document de-escalation techniques, rules would have to be revised to require the routine reporting of "Description of De-escalation Techniques Employed". Also, DFPS notes that licensed residential child care facilities may be resistant to reporting de-escalation techniques.

In order to implement a national certification process for training, as suggested by Recommendation #5, DFPS indicates that rule changes would ultimately be necessary for implementation. Additionally, the potential fiscal impact of such a requirement to the facilities regulated by DFPS would create a challenge in getting the necessary rule revision adopted.

Department of Aging and Disability Services

With respect to Recommendation #1, data collection requirements, DADS reports that the recommendation can be implemented provided adequate resources are available to develop or modify existing automated data collection systems, educate and train providers and conduct data verification. More specifically:

- ICF/MR and ALF– Current rules would have to be revised to require providers to collect all the required data elements and report to DADS. In addition, rules would have to be developed to require facilities to develop policies and procedures to conduct self-evaluations of their emergency restraints; review and compare aggregate data with facility data on emergency restraints in order to determine their effectiveness; and revise facility policies and procedures as needed. Seclusion is prohibited; therefore, rules will not include a requirement to document such instances. DADS would be required to develop an operational definition of self-evaluation and requirements for reviewing aggregate data.

- HCS – Current rules would have to be revised to require the collection of additional data elements as described in Attachment D of the workgroup report. Current rules already require HCS Program providers to review certain critical incident data (e.g., emergency restraint) with its consumer advisory committee in order to assess trends that will assist in the development of procedures to decrease the frequency of restraint use.

- NF – Current rules would need have to be revised to require providers to collect and report the data elements and perform a self-evaluation.

Other implications of the recommendation include resource constraints. For NFs and ALFs, an automated data collection system could have to be created; for ICFs/MR and HCS, the existing data collection would have to be modified in order to capture all required data. Due to limited information technology resources and competing demands, additional resources may be needed.

Additionally, in order to implement a new or revised data collection system, provider education and training would be required. Given the volume of DADS providers, a determination would have to be made if this can be done using current resources or if additional resources are needed.

Finally, in order to ensure data integrity, a data verification process would be required. Additional study is required to determine if this is feasible using existing resources.

In response to the S.B. 325 work group's second recommendation, there are several sets of rules state and federal rules that prescribe parameters related to intake, including the use of an interdisciplinary team to consider if restraint is to be used and another rule that relates specifically to behavioral management issues. For full implementation, rule revisions would be required for ALF, NF, ICF/MR and facilities to mandate the use of a prescribed form and rules governing HCS programs would have to be revised to add requirements for collection of individual preferences and the use of a prescribed form. Implementation could require additional resources for provider education and training.

DADS indicates that rules governing ICF/MR, HCS and NF programs would have to be revised in order to implement Recommendation #4 which requires competency-based training for staff involved in restraint and seclusion interventions. Regulated programs would be required to submit proposed curriculum to the agency for review. Rules would have to be revised. This recommendation could result in additional requirements for providers to meet and additional resources may be needed by the agency to review and approve curricula.

With respect to implementation of recommendation #7, DADS would have to revise ICF/MR rules to define a small facility for the purpose of allowing an exemption from the requirement for an observer during prone and supine restraints. However, DADS would take advantage of the current regulatory framework and seek to adopt rules consistent with one of their existing definitions for a "small facility." HCS rules would also require rule revisions to define a small facility.

Department of State Health Services

Recommendation #1, related to data collection and reporting would likely require additional resources to develop standardized reports for chemical dependency facilities, private psychiatric hospitals and crisis stabilization units licensed under 25 TAC Chapter 134, and hospitals licensed under 25 TAC Chapter 133. Further, revisions to rules would have to be adopted to include the reporting requirements. While facilities under the regulation of DSHS are required to report incidents of restraint and seclusion, rules would have to be expanded to require each facility to report the data as required in this recommendation.

In terms of resource challenges, DSHS indicates that the recommendation would require the addition of considerable resources to collect, aggregate, report, and distribute the data to individual facilities, human resources and information technology. Determining the process for centralized reporting and the addition of both human and information technology resources would be required. Finally, there may be additional resource needs in order to manage the additional reporting, data entry, and maintenance of data, as well as regulatory oversight of the new reporting and self-evaluation requirements.

Regarding Recommendation #2, a common intake form, DSHS notes that State hospitals currently collect information regarding advance agreements/directives and individual preferences at the time of admission, but 25 TAC Chapter 415 does not specifically require collection of information from the patient. In order to implement this recommendation, rules may have to be adopted.

While 25 TAC Chapter 448, Chemical Dependency Treatment Facilities regulations, already contemplates consideration of specified types of information at intake, full implementation of this recommendation would require rule revisions to require facilities to collect specified information at intake, or at the earliest practical time concerning client preferences during a behavioral emergency. The agency would also have to require chemical dependency treatment facilities to develop systems for collecting information regarding advanced directives and patient preferences at the time of admission.

Additional training resources may be needed for state hospitals to develop and implement intake processes and the agency may experience an unknown cost due to the need for additional regulatory oversight to enforce new rule requirements. The regulated facilities are also likely to have to invest additional staff and training resources to implement the new requirements.

DSHS indicates that additional procedures and resources may be required to implement Recommendation #3, related to field testing best practices. The agency does not currently have a formal system for field-testing best practices, promising practices, and consensus thinking and there are no incentive programs in place to promote field-testing.

For facilities regulated under 25 TAC Chapter 133, 134, and 448 encouraging and analyzing field tests is outside the regulatory function of licensing, inspecting and investigating facilities. If it is determined that this recommendation is best implemented in a non-contractual manner, mandated procedures and reporting mechanisms for facilities undertaking field tests would have to be prescribed by rule.

Further, for Chapter 134, 133 and 448 facilities, this recommendation would involve additional costs and staff, to research, establish, and implement procedures and incentives for field-testing, and to collect and analyze field-testing results. Facilities would also experience implementation and staff training costs. In the chemical dependency treatment facilities, development of field-testing would most likely fall within the purview of contractual relationships with funded providers. Any meaningful incentives would likely be financial, in which case budget constraints/limitations could influence implementation.

For state hospitals, rule revisions are required to implement this recommendation, detailing how facilities should develop a process for field-testing and to apply incentives for field-testing. Additional resources will likely be required in state hospitals for development of procedures, identification of incentives, and training.

In order to implement Recommendation #4, regarding competency based staff training, rule revisions would be required for TAC Chapter 415, Intervention in Mental Health Programs, and by reference, 25 TAC Chapter 133 and Chapter 134. For Chemical Dependency Treatment Facilities, 25 TAC Chapter 448, rule revisions would be required to add certain components to required facility training to fully meet the work group recommendation.

Rules would also be needed to require facilities to submit their proposed curriculum to the agency for review and approval, to establish a schedule for doing so, and to establish minimum curricula requirements necessary to ensure that facilities meet minimum training requirements.

In addition, for facilities regulated under 25 TAC Chapter 133, Chapter 134, and Chapter 448, the requirement that the agency review and approve facility curricula presents challenges. This recommendation would require resources to hire additional staff with the expertise to review and approve curricula. It should be noted that many facilities meet early intervention/de-escalation/restraint and seclusion training requirements through outside training providers not subject

to DSHS regulation and who may not be willing to turn over their training materials to the facilities for agency review.

The recommendation to CMHS, suggesting a national certification process for training programs, can be implemented without additional rules. However, mandating national certification and the use of a nationally approved or developed training program, if one were to be developed, would have to be implemented with the passage of additional rules.

With respect to Recommendation #7, defining a "small facility" would require rule revision. In this manner, the revisions to 25 TAC Chapter 448 defining small facilities as less than 8 licensed beds could be adopted and all DSHS divisions would be in agreement.

Texas Juvenile Probation Commission

In response to Recommendation #1, TJPC indicates that discussions regarding how to incorporate the "self-evaluation" component, will have to be initiated. In addition, issues of local control and unfunded (or under funded) mandates are inherent with any rule making process the TJPC undertakes, and those claims are sure to be a challenge in any additional rules and requirements we propose for the local governmental entities served by TJPC. Further, resource issues will have to be assessed within the agency with respect to MIS and workforce capacity.

TJPC states that Recommendation #2, the adoption of a common intake form, will require a modification of the specific standards relating to intake admission for both pre and post-adjudication youth. However, the TJPC anticipates a challenge would arise in the form of a question as to relevancy and appropriateness in the context of a correctional setting. It is anticipated that many facility administrators will not want to customize their restraint practices based on an individual client's preference when they consider facility policies and security concerns a priority.

Texas Youth Commission

Regarding Recommendation #1, collection and reporting of certain data elements, resource constraints will present a challenge, if the agency is required to aggregate the number of de-escalation techniques employed prior to use of physical restraint. As stated, the agency can provide a description of de-escalation techniques, as requested in the recommendation and specified in the first S.B. 325 Report.

Appendix A
Senate Bill 325 Work Group Recommendations

Recommendation #1

Each agency will develop rules for reporting instances of restraint and seclusion. This information will be reported to HHSC in the aggregate, by facility type, in a format to be developed by HHSC. At least annually, each health and human services agency will provide a report to individual facilities that summarizes the use of restraint and seclusion by facility type for the purposes of the individual facilities performing a self evaluation of their restraint and seclusion practices. Agencies shall develop rules requiring regulated facilities to perform self-evaluations related to restraint and seclusion usage.

Recommendation #2

All agencies should work together to develop a format for collecting the same information at the time of intake (or earliest practical time), related to individualized advance agreements and/or the individual's preferences for procedures during emergency behavioral situations. Such intake information should be secured from the facility resident or that resident's Legally Authorized Representative (LAR) or guardian, when applicable.

Recommendation # 3

State agencies should develop procedures for field-testing the best practices, promising practices, and consensus thinking identified in this report at facilities that are regulated by them. Incentives should be developed to encourage facilities to voluntarily participate in the field-testing of best practices or other innovations that reduce the use of restraint and seclusion.

Recommendation # 4

Each agency will develop rules requiring the facilities under its purview to review and revise staff (including contract staff) training protocols to ensure that training is competency-based, appropriate for populations served, and incorporates a range of early intervention techniques, de-escalation techniques, and appropriate use of restraint and seclusion as a last resort. Facilities under the purview of the agency should be required to submit their proposed curriculum to the agency for review and approval in accordance with a schedule to be defined by each agency's rules.

Recommendation # 5

Texas should recommend that the Center for Mental Health Services (CMHS), or other appropriate federal agency, should develop a national certification process for training programs, trainers, and trainees in order to provide states with reliable and state of the art and best practice training programs.

Recommendation # 6

A follow-up work group should be convened that will develop practice guidelines for the use of emergency medical interventions, including the use of medication, and other medical restraints. The work group should be sponsored by the Department of State Health Services and should include representatives from the Texas Medical Association, the Texas Hospital Association, the Texas Pharmacy Association and other groups that represent entities that use emergency medication/medical interventions for the purposes of modifying behavior.

Recommendation # 7

Individual health and human services agencies should work with constituents and stakeholders and develop rules that defines what constitutes a “small facility” for the purposes of exemption from the requirement of the presence of an observer during the administration of prone or supine holds identified in Section 322.051(b)(3) of S.B. 325.

Appendix B
Detailed Responses to Legislative Report Recommendations

Following each recommendation, each HHSC agencies' comments, as well as those of the Texas Youth Commission and the Texas Juvenile Probation Commission, are provided in greater detail.

Recommendation #1

> Each agency will develop rules for reporting instances of restraint and seclusion that include, at a minimum, the data found in Appendix D. This information will be reported to HHSC in the aggregate, by facility type, in a format to be developed by HHSC. At least annually, each health and human services agency will provide a report to individual facilities that summarizes the use of restraint and seclusion by facility type for the purposes of the individual facilities performing a self evaluation of their restraint and seclusion practices. Agencies shall develop rules requiring regulated facilities to perform self-evaluations related to restraint and seclusion usage.

The following are the requirement listed in Appendix D of the S.B. 325 workgroup report:

Seclusion/Restraint/De-escalation Reporting
Number of Seclusion Episodes
Number of Personal Restraint Episodes
Number of Mechanical Restraint Episodes
Number of Involuntary Emergency Medication Orders
Description of De-escalation Techniques Employed
Did the intervention result in an incident of serious injury or death? If so reference incident report.

Department of Family and Protective Services

Can the recommendation be implemented?

DFPS indicates that the recommendation can be implemented. While some applicable rules changes are anticipated in January 2007, other components of the reporting requirements would require further rule modification.

Of special note, with regard to reporting by facility type, due to changes in classification of facility types which will be effective on January 1, 2007, DFPS will no longer be able to report data specific to children receiving treatment services for mental retardation – as would have been the case prior to the reclassifying effort. This is noted to ensure that the requirement relative to reporting by facility type recognizes the newly classified facility types.

Rule Changes Needed?

As of January 1, 2007 will require facilities that DFPS regulates to report to DFPS quarterly, aggregate numbers of personal restraints, mechanical restraints, seclusions, and incidents in which emergency medication was administered. However, it should be noted that DFPS does not currently distinguish between voluntary and involuntary emergency medications which would require further rule revisions.

Other Obstacles?

DFPS notes that licensed residential child care facilities may be resistant to reporting de-escalation techniques.

Department of Aging and Disability Services

Can the recommendation be implemented?

DADS reports that the recommendation can be implemented provided adequate resources are available to develop or modify existing automated data collection systems, educate and train providers and conduct data verification.

Rule Changes Needed?

- ICF/MR and ALF– Current rules must be revised to require providers to collect all the required data elements and report to DADS. In addition, rules would have to be developed to require facilities to develop policy and procedure to conduct self-evaluations of their emergency restraints; review and compare aggregate data with facility data on emergency restraints in order to determine their effectiveness; and revise facility policy and procedures as needed. Seclusion is prohibited; therefore, rules will not include a requirement to document such instances. DADS will have to develop an operational definition of self-evaluation and requirements for reviewing aggregate data.

- HCS – Current rules must be revised to require the collection of additional data elements as described in Attachment D. Current rules already require HCS Program providers to review certain critical incident data (e.g., emergency restraint) with its consumer advisory committee in order to assess trends that will assist in the development of procedures to decrease the frequency of restraint use.

- NF – Current rules must be revised to require providers to collect and report the data elements as described in Attachment D and perform a self-evaluation.

Rules would not be required for DADS to submit data to HHSC or provide an annual aggregate report to providers.

Other Obstacles?

For NFs and ALFs, an automated data collection system will have to be created; for ICFs/MR and HCS, the existing data collection must be modified in order to capture all required data. Due to limited information technology resources and competing demands, additional resources may be needed.

In order to implement a new or revised data collection system, provider education and training would be required. DADS provider base includes 890 ICFs/MR; 965 HCS contracts; 1,146 ALFs; and 1,169 NFs. DADS will have to determine if this can be done using current resources or if additional resources are needed.

Operational requirements related to a self-assessment would be required.

In order to ensure data integrity, a data verification process would be required. Additional study is required to determine if this is feasible using existing resources.

Department of State Health Services

Can the recommendation be implemented?

DSHS indicates that the recommendation can be implemented but it would require the addition of considerable resources to collect, aggregate, report, and distribute the data to individual facilities, human resources and information technology.

Currently, only the state hospitals have developed a standardized system for reporting restraint and seclusion data. State hospital data are also reported nationally to the Joint Commission of Accreditation of Healthcare Organizations (JCAHO) through the performance measurement system of the National Association of State Mental Health Program Directors Research Institute. This allows comparison with other states.

Chemical Dependency facilities, private psychiatric hospitals and crisis stabilization units licensed under 25 TAC Chapter 134, and hospitals licensed under 25 TAC Chapter 133 would have to develop standardized reports and would likely have to add additional resources in order to do so.

Rule Changes Needed?

Revisions to 25 TAC Chapter 415, Subchapter F, would have to be revised to include the reporting requirements. Further 25 TAC Chapter 133 and Chapter 134 could adopt Provider Clinical Responsibilities - Mental Health Services, Interventions in Mental Health Programs (Chapter 415) by reference following 25 TAC Chapter 415, Subchapter F revisions.

While facilities under the regulation of DSHS are required to report incidents of restraint and seclusion, rules would have to be expanded to require each facility to report the data as required in this recommendation.

Other Obstacles?

Determining the process for centralized reporting and the addition of both human and information technology resources will be required. There will be an unknown cost impact on the agency to handle the additional reporting, data entry, and maintenance of data, as well as in regulatory oversight of the new reporting and self-evaluation requirements.

Texas Juvenile Probation Commission

The TJPC has comprehensive provisions regarding the use of restraints in its facility specific standards. However, the TJPC will be pursing the adoption of additional rules (i.e., standards) to further harmonize their standards and the specific provisions of SB 325, and the applicable workgroup recommendations. Where specific Administrative Rules are inappropriate or non-applicable, the TJPC will explore options involving its contracting authority related to the distribution of State funding mechanisms.

Discussions regarding how to incorporate the "self-evaluation" component of this recommendation will have to be initiated. Issues of local control and unfunded (or under funded) mandates are inherent with any rule making process the TJPC undertakes, and those claims are sure to be an obstacle in any additional rules and requirements we propose for the local governmental entities we serve. Further resource issues will have to be assessed within the agency with respect to MIS and workforce capacity.

Texas Youth Commission

Can the recommendation be implemented?

All aggregate data can be reported, although TYC does not currently aggregate de-escalation techniques. However, a "description" of de-escalation techniques employed prior to the use of physical restraint can be reported and the agency will expand the range of de-escalation codes to enhance descriptive reporting on progressive interventions. Finally, reporting on serious injury or death can be extracted and identified with an incident report.

Other Obstacles?

TYC reports that resource constraints will present an obstacle, if the agency is required to aggregate the number of de-escalation techniques employed prior to use of physical restraint. As stated, the agency can provide a description of de-escalation techniques, as requested in the recommendation and specified in Appendix D of the S.B. 325 Report.

Recommendation #2

> All agencies should work together to develop a format for collecting the same information at the time of intake (or earliest practical time), related to individualized advance agreements and/or the individual's preferences for procedures during emergency behavioral situations. Such intake information should be secured from the facility resident or that resident's Legally Authorized Representative (LAR) or guardian, when applicable.

Department Family and Protective Services

Can the recommendation be implemented?

In general, DFPS notes that this recommendation is not applicable to their regulated facilities. However, the new DFPS standards for residential child-care include a new rule, effective January 1, 2007, requires each operation to obtain at admission each child's input on preferred de-escalation techniques and revisit this information after each emergency behavior intervention.

Rule Changes Needed?

Depending on the format and the type of information that the HHSC agencies agree to use, DFPS may be able to use its existing rule to implement this section.

Other Obstacles?
If the format is too specific, it may be difficult to enforce the uniformity through regulation.

Department of Aging and Disability Services

Can the recommendation be implemented?

DADS states that it is possible to implement this recommendation if resources are available for provider education and training.

Rule Changes Needed?

- ICF/MR - and MR facilities currently follow requirements prescribed by state and federal law that are followed at intake that entail the elements of this recommendation. However, rule revisions would be required in order to mandate use of a prescribed form.

- HCS – Rules would have to be revised to add requirements for collection of individual preferences and the use of a prescribed form.

- NF – Rules currently provide that each resident and the resident's LAR are notified of the rules and policies related to restraints and seclusion. Additional rules require facilities to develop a comprehensive care plan within 14 calendar days of admission for each resident that includes measurable short-term goals and long-term objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. However, rule revisions would be required in order to mandate use of a prescribed form.

- ALF - Existing rule language requires a comprehensive assessment (intake information); therefore, a rule revision is not needed to require a process. However, rule revisions would be required in order to mandate use of a prescribed form.

Other Obstacles?

Provider education and training may require additional resources.

Department of State Health Services

Can the recommendation be implemented?

State hospitals currently collect information regarding advance agreements/directives and individual preferences at the time of admission, but governing rules do not specifically require collection of that information from the patient. The agency will also have to require chemical dependency treatment facilities to develop systems for collecting information regarding advanced directives and patient preferences at the time of admission.

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Rule Changes Needed?

Rules governing Mental Health intervention programs, Chapter 415, will require revision.

For facilities regulated by 25 TAC Chapter 133 and Chapter 134 it may be possible to adopt 25 TAC Chapter 415 Provider Clinical Responsibilities—Mental Health Services, Subchapter F Interventions in Mental Health Programs by reference.

For chemical dependency treatment facilities, consideration of specified types of information obtained during the client assessment is already contemplated by 25 TAC § 448.706(f)(4), but full implementation would require rule revisions. Passage of additional rules will be necessary to require facilities to collect specified information at intake, or at the earliest practical time concerning client preferences during a behavioral emergency.

Other Obstacles?

Additional training resources may be needed for state hospitals to develop and implement processes.

There may be an unknown cost impact on the agency caused by the need for additional regulatory oversight to enforce new rule requirements for facilities regulated under 25 TAC Chapter 133, Chapter 134, and Chapter 448. The regulated facilities are also likely to have to invest additional staff and training resources to implement the new requirements.

Texas Juvenile Probation Commission

This recommendation will require a modification of the specific standards relating to intake admission for both pre and post-adjudication youth. Upon initial review, the anticipated rules in question would not appear to be cost prohibitive as they most likely would involve a specialized interview questionnaire (etc.). However, the TJPC anticipates an obstacle would arise in the form of a question as to relevancy and appropriateness in the context of a correctional setting. It is anticipated that many facility administrators will not want to customize their restraint practices based on an individual client's preference when they consider facility policies and security concerns a priority.

Texas Youth Commission

Facility residents are currently assessed by a psychologist to determine the youth's motivation for the aggressive behavior and to recommend program and staff interventions necessary for youth to develop internal behavioral controls. The agency employs several behavioral management treatment plans enumerated in GAP 97.16 related to Primary Intervention Program and GAP 95.17 related to Behavioral Management Program. TYC requires standardized intake information on every youth committed to the agency. Intake assessment includes the delinquent history, family/developmental history, initial behavioral adjustment in TYC, and various additional assessments (e.g., medical, educational, psychiatric). A forensic psychological evaluation is conducted to assess the juvenile's history and prior aggression and to render treatment recommendations. Standardized intake assessment assists clinical and direct care staff in developing individualized case plans and behavioral intervention plans.
The adoption of a standardized intake form could occur without the passage of rules.

Recommendation # 3

> State agencies should develop procedures for field-testing the best practices, promising practices, and consensus thinking identified in this report at facilities that are regulated by them. Incentives should be developed to encourage facilities to voluntarily participate in the field-testing of best practices or other innovations that reduce the use of restraint and seclusion.

Department of Family and Protective Services

Can the recommendation be implemented?

DFPS continues to work toward a different model of contracting for residential child care services. There may be several opportunities to implement this group of recommendations.

Rule Changes Needed?

Unknown

Other Obstacles?

No known obstacles at this time.

Department of Aging and Disability Services

Can the recommendation be implemented?
Rule Changes Needed?
Other Obstacles?

DADS states that additional information is needed regarding best practices, consensus thinking, and promising practices related to the populations served in DADS programs. Towards this effort, DADS will use its contract with Texas A&M to conduct a Systematic Literature Review (SLR) across several topics:

Use of Incident Reporting in Programs for People with Developmental Disabilities. For this review, "incident" is any actual or alleged event or situation that creates a significant risk of substantial or serous harm to the physical or mental health, safety, or well being of a participant. Examples include, but are not limited to, the use of restraints to control behaviors; and

Managing Maladaptive Behaviors in People with Developmental Disabilities. For this review, "maladaptive behaviors" refers to any self-injurious, verbally aggressive, or physically violent behaviors that impact a person's quality of life, or those around the person.

DADS requested Texas A&M to incorporate into the SLR, the Reference and Resource List (Appendix C of the SB 325 report compiled by HHSC, September 2006).

Research findings will be evaluated for application to all of DADS programs. When best practices, etc., are identified, DADS will work with stakeholders to determine the most effective means by which to encourage implementation by providers.

Department of State Health Services

Can the recommendation be implemented?

DSHS indicates that additional procedures and resources may be required. The agency does not currently have a formal system for field-testing best practices, promising practices, and consensus thinking and there are no incentive programs in place to promote field-testing.

For facilities regulated under 25 TAC Chapter 133, Chapter 134, and Chapter 448 encouraging and analyzing field tests is outside the regulatory function of licensing, inspecting and investigating facilities. Program staff dealing with funded providers may be in the best position to implement this recommendation through their contractual relationships with funded providers. Meaningful incentives would likely have to be financial, in which case budget constraints/limitations could influence implementation.

Rule Changes Needed?

For state hospitals, rule revisions are required to implement this recommendation detailing how facilities should develop process for field-testing and to apply incentives for field-testing.

With respect to facilities regulated under 25 TAC Chapter 133, Chapter 134, and Chapter 448, program areas dealing with funded providers are probably in the best position to assess whether procedures and incentives can be developed as part of the agency's contractual relationships with providers. If non-contractual, mandated procedures and reporting mechanisms are contemplated for facilities undertaking field tests that would have to be prescribed by rule.

Other Obstacles?

Additional resources will likely be required in state hospitals for development of procedures, identification of incentives, and training.

For facilities regulated under 25 TAC Chapter 133, Chapter 134, and Chapter 448, implementation of this recommendation would involve additional costs and staff to research, establish, and implement procedures and incentives for field-testing, and to collect and analyze field-testing results. Facilities themselves would also experience implementation and staff training costs. In the chemical dependency treatment facility context, development of field testing would most likely fall within the purview of contractual relationships with funded providers.

Texas Juvenile Probation Commission

The TJPC is currently discussing incentive programs or the replication or modeling of programs which have minimized the use of seclusion and restraint practice. Specifically:

- Staff from the TJPC and three local jurisdictions (Bexar, El Paso, and Randall Counties) recently participated in the Hogg Foundation sponsored conference entitled, Creating Violence Free Coercion Free Mental Health Treatment Environments for the Reduction of Seclusion and Restraint. The TJPC intends to include these three jurisdictions in a technical assistance consortium to assist other jurisdictions in their assessment of their restraint and seclusion reduction efforts. It is hoped that this peer modeling concept will be more effective in changing facility specific restraint and seclusion cultures than simple rule compliance directives.
- Additionally, the TJPC is going to make a concerted effort to publicly (e.g., agency newsletter, etc.) recognize jurisdictions that have made significant reductions in the use of restraints and seclusion.

The TJPC anticipates no significant obstacles in this effort, other than those associated with time constraints on the staff resources of the involved entities.

Texas Youth Commission

Can the recommendation be implemented?

TYC currently conducts pilot/ field tests training and tracks performance indicators to measure the effectiveness of training programs.

Rule Changes Needed?

TYC indicates that no new rules will be needed and current training programs are presented for approval at by executive personnel and agency training is monitored through performance indicators.

Recommendation # 4

> Each agency will develop rules requiring the facilities under its purview to review and revise staff (including contract staff) training protocols to ensure that training is competency-based, appropriate for populations served, and incorporates a range of early intervention techniques, de-escalation techniques, and appropriate use of restraint and seclusion as a last resort. Facilities under the purview of the agency should be required to submit their proposed curriculum to the agency for review and approval in accordance with a schedule to be defined by each agency's rules.

Department of Family and Protective Services

Can the recommendation be implemented?

DFPS already reviews and approves emergency behavior intervention policies and training for compliance with Licensing standards at the point of a facility's application to be licensed, which detail the required training curriculum and standards, including a requirement that the training be competency-based. Facilities must notify DFPS if their policies change, and policies are required to include a description of the training curriculum. DFPS also requires each facility to annually re-evaluate the effectiveness of their emergency behavior intervention program, including policies and training curriculum.

Rule Changes Needed? No
Other Obstacles? None

Department of Aging and Disability Services

Can the recommendation be implemented? Rule Changes Needed?

ICF/MR, HCS and NF – DADS indicates that rules must be revised to require competency-based training for behavioral issues and submission of proposed curriculum to the agency for review.

ALF - Current rule language at 40 TAC §92.41(a)(4)(B)-(D) requires staff training and competency of staff. No rule revision is necessary for this portion of the recommendation, however, rules would be required for submission of proposed curriculum to the agency for review.

State MR facilities governing the use of restraint already detail competency-based training requirements appropriate to the position and responsibilities of staff [§5.363].

Other Obstacles?

This would result in an increased financial burden on providers. DADS indicates that it may need additional resources to review and approve curricula. There is also potential liability associated with the approval of curricula that requires further consideration.

Department of State Health Services

Can the recommendation be implemented?

For state hospitals, HHSC Facility Support Services Competency Training and Development develops training protocols. It is unclear how this process would impact resources in that division.

For facilities regulated under 25 TAC Chapter 133, Hospital Licensing and Chapter 134, Private Psychiatric Hospitals and Crisis Stabilization Units, this could be implemented with the hiring of additional staff with the expertise to review and approve curriculum.

For 25 TAC Chapter 448 regulations, Chemical Dependency Treatment Facilities, this could be implemented with the hiring of additional staff with the expertise to review and approve curriculum. Most of the training components to be required of facilities are already mandated by rule, at 25 TAC § 448.603, but certain revisions would be required to meet all of the components of the recommendation, and there is no mechanism currently in place for facility submission and agency review of facility curricula.

Rule Changes Needed?

The following rule revisions are required to implement this recommendation:

25 TAC Chapter 415, Intervention in Mental Health Programs, will require rule revisions.

25 TAC Chapter 133 and Chapter 134: adopt 25 TAC Chapter 415 Provider Clinical Responsibilities—Mental Health Services, Subchapter F Interventions in Mental Health Programs by reference.

25 TAC Chapter 448, Chemical Dependency Treatment Facilities, rule revisions would be required to add certain components to required facility training to fully meet the workgroup recommendations. Rules would also be needed to require facilities to submit their proposed curriculum to the agency for review and approval, to establish a schedule for doing so, and to establish minimum curricula requirements necessary to ensure that facilities meet minimum training requirements.

Other Obstacles?

DSHS states that for state hospitals, this recommendation would have more impact on the resources available from the HHSC Facility Support Services Competency and Training Development.

For facilities regulated under 25 TAC Chapter 133, Chapter 134, and Chapter 448, the requirement that the agency review and approve facility curricula presents a number of significant obstacles.

- Curriculum approval requires a level of specialized expertise that cannot be assumed to exist among current staff, and would require additional staff to accomplish. Many facilities meet early intervention/de-escalation/restraint and seclusion training requirements through outside training providers not subject to DSHS regulation and who may not be willing to turn over their training materials to the facilities for agency review.

- Moreover, if best practice components ("de-escalation techniques, early intervention techniques, appropriate use of restraint and seclusion," etc.) within the curriculum are the focus, without generally accepted standards for appropriate and effective curriculum to teach those components, there is the potential for a broad range of curricula being submitted and potentially approved among agency programs and between agencies which would undermine the intent of this recommendation.

Texas Juvenile Probation Commission

The TJPC currently requires that all facilities under its regulatory authority utilize a personal restraint technique which requires a formalized certification process that is competency based. The TJPC has already initiated and is near completion (anticipated completion in January 2007) of a formalized personal restraint curriculum review process that helps ensure the competency-based component of each curriculum being used.

The TJPC does not think there is a need for any additional rule making efforts in this regard, nor, does the TJPC anticipate any obstacles to the above mentioned efforts already underway.

Texas Youth Commission

Can the recommendation be implemented?

TYC indicates that physical restraint training is currently competency based. The agency is field testing enhanced competency based training on de-escalation communications skills, behavioral management intervention, and on-the job-training. Enhanced training will expand the staff competencies on progressive de-escalation interventions to reduce the use of physical restraint. Consistent with Recommendation 4, training enhancements are piloted/ field tested prior to agency implementation. Physical restraint training has also been enhanced consistent with adopted policy on Use of Force, GAP 97.23.

Rule Changes Needed?

Recommendation is currently implemented through required training standards therefore not requiring new rules or standards.

Recommendation # 5

> Texas should recommend that the Center for Mental Health Services (CMHS), or other appropriate federal agency, should develop a national certification process for training programs, trainers, and trainees in order to provide states with reliable and state of the art and best practice training programs. (See Section II)

Department of Family and Protective Services

Can the recommendation be implemented?

Earlier in the year when DFPS proposed rule changes, largely as a result of the costs involved, facilities regulated by DFPS expressed concern about being required to use only nationally recognized programs,.

Rule Changes Needed?
DFPS indicates that rule changes would be necessary to implement this recommendation.

Other Obstacles?
The potential fiscal impact of such a requirement to the facilities that regulated by DFPS would create a challenge in getting the necessary rule revision adopted.
Department of Aging and Disability Services- No response

Department of State Health Services

Can the recommendation be implemented?

The recommendation to CMHS would not be implemented at the state agency level. The expense to agencies and facilities to implement a national certification process, if developed, can't be anticipated at this point.

Rule Changes Needed?

The recommendation to CMHS can be implemented without additional rules. Mandating national certification and the use of a nationally approved or developed training program, if one were to be developed, would have to be implemented with the passage of additional rules.

Other Obstacles?

Requiring facilities to utilize a training program that has received a national certification may have an impact on budgets and produce a monetary burden. There would also be an unknown cost impact on the agency caused by the need for additional regulatory

oversight to enforce new rule requirements associated with any national certification requirements.

Texas Juvenile Probation Commission

The TJPC would gladly endorse such a request being made of the CMHS. The TJPC can think of no rule making needs or anticipated obstacles being associated with such an endorsement or request.

Texas Youth Commission

Pending Center for Mental Health national certification process to comment on rules and obstacles, TYC indicates that they could support this effort.

Recommendation # 6

> A follow-up work group should be convened that will develop practice guidelines for the use of emergency medical interventions, including the use of medication, and other medical restraints. The work group should be sponsored by the Department of State Health Services and should include representatives from the Texas Medical Association, the Texas Hospital Association, the Texas Pharmacy Association and other groups that represent entities that use emergency medication/medical interventions for the purposes of modifying behavior. (See Section III)

Department of Family and Protective Services

DFPS would certainly provide an agency representative, if such a work group is convened.

Department of Aging and Disability Services- No response

Department of State Health Services

Can the recommendation be implemented?

State hospitals, substance abuse services, and regulatory services at DSHS will have to be involved in development of any new rules or rule revisions relevant to the use of emergency medications or medical restraints.

Rule Changes Needed?

No rule revisions are required to implement the work group portion of this recommendation but revisions could be required as a result of work group recommendations.

Other Obstacles?

There would be no obstacles to creating or participating in the workgroup, other than the resources involved in any staff participation.

Texas Juvenile Probation Commission

Though the practice of emergency medical interventions is not prevalent in the programs the TJPC regulates, the TJPC would support the creation of such a work group. The TJPC could use any anticipated guidelines and recommendations the work group might make to better educate and inform the programs we serve on better defining which client behaviors warrant emergency medical interventions and the protocols associated with those interventions. The need for additional rules in this area would be minimal, if even necessary, and the TJPC does not anticipate any obstacles to any related efforts.

Texas Youth Commission

While TYC does not believe this recommendation to be applicable to their operations, the agency will re-evaluate its application pending follow-up workgroup practice guidelines.

Recommendation # 7

> Individual health and human services agencies should work with constituents and stakeholders and develop rules that defines what constitutes a "small facility" for the purposes of exemption from the requirement of the presence of an observer during the administration of prone or supine holds identified in Section 322.051(b)(3) of S.B. 325. (See Section III).

Department of Family and Protective Services

Can the recommendation be implemented?
This has already been accomplished through our recent rules adoption process. The new rules which go into effect January 1, 2007, include §748.2605, which indicates that facilities with a capacity of 16 or fewer children are exempt from the requirement that the person monitoring the personal restraint must not be involved in the restraint.

Rule Changes Needed? N/A
Other Obstacles? N/A

Department of Aging and Disability Services

Can the recommendation be implemented?

ICF/MR - the ICF/MR program already includes definitions of a "small facility" that were developed for different purposes: one for provider payments (facilities with 8 or

fewer beds) and another related to Life Safety Code (facilities with 17 or fewer beds). The CFR §483.430 (c) also refers to "more than 16 clients" or "fewer than 16 clients" regarding staff to be available on a 24-hour basis. DADS would have to revise rules to define a small facility for the purpose of allowing an exemption from the requirement for an observer. DADS would seek to adopt rules consistent with one of the existing definitions for a "small facility."

HCS and NF- Rule revisions would be required to define a small facility. However, since HCS rules prohibit the use of prone and supine restraint, revisions related to this provision are not applicable.

ALF – A "small facility" is already defined in 40 TAC §92.61(a)(1) and the Life Safety Code, National Fire Protection Association (NFPA 101). Rules would be required to define a small facility for the purpose of this recommendation. However, ALF rules prohibit the use of prone and supine restraint so revisions related to this provision are not applicable.

Rule Changes Needed?
Other Obstacles?

Department of State Health Services

Can the recommendation be implemented?

DSHS will have to be involved in development any new rules or rule revisions.

Rule Changes Needed?

25 TAC Chapter 415, Subchapter F, Intervention in Mental Health Programs, would require revision. The revisions to 25 TAC Chapter 448 defining small facilities as less than 8 licensed beds could be adopted and all DSHS divisions would be in agreement.

25 TAC Chapter 133 and Chapter 134 could adopt 25 TAC Chapter 415 Provider Clinical Responsibilities—Mental Health Services, Subchapter F Interventions in Mental Health Programs by reference. Chapter 415 prohibits a prone or supine hold except to transition an individual into another position and shall not exceed one minute in duration.

Other Obstacles?

None

Texas Juvenile Probation Commission

Currently, the TJPC does not require a secondary "observer" in prone and supine restraints. Therefore, our response is not really applicable. To date the TJPC has no

standards that relate to a facility's size and all of our standards have universal applicability.