Note: The following email was distributed on behalf of Stan Mrozowski on May 10, 2013 to all Pennsylvania county/BHMCOs and the OMHSAS field offices, accompanied by the PA Integrated PCIT Policy Clarification and Time-Out Space Guidelines

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This email is sent on behalf of Stan Mrozowski

Attached are guidelines that address the use of time out, which is a fundamental component of Parent Child Interaction Therapy, in the context of OMHSAS focus on preventing trauma. The attached documents are the result of a collaboration between Amy Herschell, the primary trainer for PCIT in Pennsylvania, and Gordon Hodas, child psychiatric consultant to the OMHSAS Children's Bureau. These guidelines are being used in designing space for PCIT in agencies and in training PCIT therapists.

Thanks,
Stan

Question re OMHSAS Bulletin 02-01, Issued 4/8/02
"The Use of Seclusion and Restraint in Mental Health Facilities and Programs" and Parent-Child Interaction Therapy (PCIT)

QUESTION

OMHSAS Bulletin 02-01, issued 4/8/01 – "The Use of Seclusion and Restraint in Mental Health Facilities and Programs" – applies to a wide range of mental health facilities and programs, including psychiatric Outpatient clinics. The bulletin prohibits the use of seclusion, except in psychiatric hospitals, and identifies the rationale for use of manual restraint to be in response to an emergency safety situation, "only after appropriate less restrictive behavioral techniques have been tried…"

Parent-Child Interaction Therapy (PCIT), an evidence-based practice for young children (2.5-7 years) with severe behavioral challenges and their families, has procedures that may involve a parent picking up and moving a child, and also may involve the use of a room for the child that is separate from the therapy room, referred to as a time-out room, a time-out space, and a safe space. Are these practices, understood within the context of PCIT as an integrated treatment for the above target population, compatible with the above OMHSAS bulletin and with other bulletins related to the use of seclusion and restraint?

BACKGROUND

1. DPW BULLETINS

- OMHSAS Bulletin 02-01, issued 4/8/01, is the primary DPW bulletin addressing seclusion and restraint that includes the setting of Outpatient mental health:
    - The bulletin indicates that restrictive procedures cannot be used as a means of coercion, discipline, convenience, or retaliation. Below are statements regarding the use of specific types of restrictive procedures.
    - Seclusion:
        - Seclusion is only permitted in private psychiatric hospitals and in psychiatric units in general hospitals as an emergency safety measure, when there is imminent danger of bodily harm to the consumer or others.
        - The use of seclusion requires a licensed physician's order, or that of a registered nurse.
        - "Seclusion" is differentiated from the use of a "time out room." A time-out room involves the child in a room that is unlocked.
        - Application to PCIT: In PCIT, the room that is called a time-out room is not locked, but the parent may hold the door to prevent the child from entering the therapy room without permission. The treatment

requires that the child have continual visual contact with the parent while in the time-out room.

- Mechanical restraint:
  - Mechanical restraints may be used only in secure care under the 3800 regulations, and under specific situations involving safety concerns in private psychiatric hospitals and in psychiatric units in general hospitals.
  - Application to PCIT: The use of mechanical restraint is not at issue with respect to PCIT.
- Chemical restraint:
  - Chemical restraint is not to be used in psychiatric Outpatient clinics and in other identified treatment settings.
  - The use of chemical restraint even in permissible settings is discouraged.
  - Chemical restraint may be used in RTFs and Inpatient facilities, if ordered by a licensed physician and needed to preserve safety.
  - Application to PCIT: The use of chemical restraint is not at issue with respect to PCIT.
- Manual restraint:
  - The use of manual restraint is permitted as an emergency safety intervention, but its use is discouraged.
  - Manual restraint is permissible in psychiatric Outpatient clinics and other identified treatment settings, but "only after appropriate less restrictive behavioral techniques have been tried."
  - Application to PCIT: PCIT does not use manual restraint as it is typically used in that manual restraint in PCIT is not implemented during an emergency. Instead, it is used in PCIT to safely get a child into the time-out room when the child does not follow the parental instruction to remain in the time-out chair in the therapy room and the child is unwilling to go into the time-out room on his/her own.
  - In addition, the following additional applications to PCIT are of relevance:
    - The formal manual restraint hold techniques typically used in facilities and based on vendor training are not used in PCIT.
    - In PCIT, the child is not restrained by a staff person or a therapist, but by the parent, who is supervised by the therapist.
    - The goal of the restraint is not to place and maintain the child on the ground, but rather to get the child safely to the time-out room next to or within the therapy room, when the child does not go willingly.
    - The parent guides, and when necessary picks up and carries, the child to the time-out room.
    - Picking up and carrying a child by a parent does constitute a manual restraint, but the nature of the intervention and the clinical circumstances are quite different from those in a facility and therefore require separate consideration.

- Additional discussion of the use of manual restraint in PCIT is provided later in this document in the section entitled, "Response to Question," specifically in the consideration of "Restraint" within that section.

- Medical Assistance Bulletin #53-01-01, effective 7/20/01 – "The Use of Restraint and Seclusion in Psychiatric Treatment Facilities (RTF)" – addresses the use of seclusion and restraint only in RTFs:
  - This bulletin prohibits the use of seclusion and mechanical restraints in RTFs.
  - The bulletin indicates that manual restraint is a permissible intervention, but one that is discouraged and to be used "at the time of an emergency safety situation and limited to the duration of the emergency safety situation."
  - The bulletin indicates that a restraint is not to be applied without an order by a designated professional.
  - Application to PCIT: The scope of this bulletin does not include child mental health Outpatient facilities. PCIT is considered to be an Outpatient treatment.

- DPW Bulletin #3800-09-02, effective 6/21/10 – "Prone Restraints in Children's Facilities":
  - This bulletin prohibits the use of prone restraint in applicable facilities.
  - Application to PCIT: The scope of this bulletin does not include child mental health Outpatient facilities. In addition, PCIT does not use prone restraint.

- DPW Bulletin #3800-09-01, effective 6/21/10 – "Strategies and Practices to Eliminate the Use of Unnecessary Restraints" – includes County Mental Health/Mental Retardation Offices:
  - The identified purpose of the above bulletin is the following:

    > *…to provide guidance to child residential and day treatment programs that are licensed, supervised, or funded by the Department of Public Welfare to assist in the implementation of strategies and practices that lead to the elimination of unnecessary restraint through promoting environments free of violence and coercion and the safe and best practice management of children.*

  - The bulletin discusses Department concerns about the risks involved in using manual restraint.
  - The bulletin also discusses how programs can implement trauma-informed care, and delineates the six best practice strategies to "help programs focus on improving the provision of care for children, resulting in the reduction of restraints and coercive practices."
  - Application to PCIT: The bulletin states the following: "The Department also recognizes that programs are at different stages of implementation and require unique implementation plans based on the needs of the children and families served and the type of services provided."

2. PARENT CHILD INTERACTION THERAPY (PCIT)

- PCIT is an evidence-based, parent-child treatment practice that helps parents or other caregivers of children with behavioral challenges – including aggression, oppositional and defiant behavior, and temper outbursts – achieve effective parenting. It also is considered to be an evidence-based treatment for families involved with child welfare as a result of high levels of physical aggression and physical abuse.

- PCIT focuses on promoting positive parent-child relationships and interactions as well as teaching parents effective child management skills.

- PCIT consists of two sequential phases:
    - The Child-Directed Interaction (CDI) phase focuses on helping the parent/caregiver improve the relationship with the child and develop consistently positive and supportive communication. The parent follows the child's lead during this phase.
    - The Parent-Directed Interaction (PDI) phase begins after the skills of the previous phase have been mastered. The focus of this phase is on helping the parent develop consistent, predictable, effective discipline and child management skills within the context of a positive parent-child relationship. The parent takes the lead in this phase.

- During all PCIT therapy sessions, the parent is guided and supported by a masters-or doctoral-level, PCIT therapist who is licensed or supervised by a licensed therapist trained in PCIT. The PCIT therapist is behind a one-way mirror and communicates directly with the parent by means of a small communication device (bug) in the parent's ear. All PCIT therapists receive extensive training from a PCIT trainer and supervision from a qualified supervisor.

- The PDI phase of treatment helps the parent set calm, safe limits with the child:
    - The child is given a specific, appropriate, achievable directive.
    - If the child does not follow the initial directive, he/she is reminded of the specific directive (given a warning).
    - If the child continues to not follow a directive, he/she is instructed by the parent to sit on a time-out chair that is in the therapy room. The child is told to remain on the time-out chair in the therapy room for 3 minutes, plus 5 seconds of quiet. The 5 seconds of quiet, which demonstrate that the child is calm, must occur following the 3 minute period, in order for the child to be permitted to get off the time-out chair.
    - If the child refuses to go to the time-out chair, the parent, coached by the therapist, first gently places his/her hand on the child's back to guide the child to time-out. If the child continues to refuse to go to the time-out chair, the parent can safely pick up the child from behind and place the child in the time-out chair.
    - If the child gets off the chair prematurely, the parent places the child back in the time-out chair and, one time only, gives the child a time-out room warning.

The message is that, if the child gets off the time-out chair again without permission, the child will need to go into the time-out room.
    - If the child gets off the time-out chair again, the child is then taken to the time-out room.
    - While the child is in the time-out room, the door is closed and the parent does not verbally respond to the child. However, the door does not have a lock (although the parent may be manually holding it closed), and the child has visual access to the parent at all times.
    - The child remains in the time-out room for 1 minute, plus 5 seconds of quiet. The 5 seconds of quiet must occur following the 1 minute period, in order for the child to be permitted to return to the therapy room.
    - Upon return to the therapy room, the child is returned to the time-out chair and remains there for 3 minutes and 5 seconds of quiet. If the child does not remain in the time-out chair, the child is placed in the time-out room again.
    - After the child has remained in the time-out chair for the 3 minutes plus 5 seconds of quiet, he or she can get off the chair, follow the original directive, and then be praised by the parent for following directions.
    - PDI sessions always end with child-directed play involving the parent and child, with the child receiving additional positive attention from the parent for appropriate prosocial behaviors.

- PCIT, initially developed in the 1970's, is an evidence-based practice listed in the National Registry of Evidence-Based Programs and Practices.

- According to an Issue Brief in January 2007 by the Child Welfare Information Gateway, published by the federal Administration on Children, Youth and Families, the unique aspects of the model, which "extend to physically abusive and at-risk biological parents as well as foster parents," involve the following six elements:
    - PCIT reduces behavior problems in young children by improving parent-child interaction.
    - PCIT decreases the risk for child physical abuse and breaks the coercive cycle. The coercive cycle involves a parent, angry with the non-cooperating child, escalating the response to involve severe corporal punishment and physical abuse.
    - PCIT offers support for caregivers, including foster parents.
    - PCIT uses live coaching.
    - PCIT treats the parent and child together.
    - PCIT has been adapted for use with various populations and cultures, including various racial and ethnic groups and families where child abuse has occurred.

- In the 07/06/2011 "OMHSAS response to concerns about use of time-out in PCIT" document, additional information is provided regarding research literature on the use of time-out procedures with young children.

- In its discussion of the effectiveness of PCIT, the Child Welfare Information Gateway issue brief identifies, among many positive outcomes, the following: reductions in the risk of child abuse, lasting effectiveness, usefulness in treating multiple issues, and adaptability for a variety of populations.

RESPONSE TO QUESTION

- At the time that OMHSAS Bulletin 02-01 was developed and then issued on 4/8/01, there were no evidence-based, outpatient treatment programs for young children with challenging behaviors in Pennsylvania's public mental health system. This includes PCIT. As a result, the unique needs of children receiving this treatment and the unique characteristics of this treatment model could not be taken into consideration in developing the bulletin.

- The previously identified DPW statement in DPW Bulletin #3800-09-01, effective 6/21/10, "Strategies and Practices to Eliminate the Use of Unnecessary Restraints" is relevant to determining the compatibility of PCIT procedures with OMHSAS bulletins on seclusion and restraint:

  The Department also recognizes that programs …require unique implementation plans based on the needs of the children and families served and the type of services provided.

- The compatibility of PCIT to OMHSAS regulations is considered below, first with respect to seclusion and then to manual restraint. This is followed by an overall conclusion.

- Seclusion:
  - The time-out chair is located in the therapy room, and placing the child in the time-out chair does not involve any separation of the child from the parent. Therefore, considerations of seclusion are clearly not applicable here.
  - The use of the time-out room does not involve locking the room, because the room in question does not have a lock.
    - However, at times in order to keep the child in the room, the parent may manually hold the door shut. Prior to implementing any part of the time-out procedure, the child has been informed of the process. During the entire time while the child is in the time-out room, he or she has visual access to the parent. The goal is to establish the need for the child to follow the parent's instruction and then return the child to the therapy room in a facilitated manner.
    - Use of the time-out room is part of the PDI phase of PCIT, which does not begin until the parent has mastered the CDI phase. With completion of the CDI phase, there is typically improved rapport between parent and child, and greater capacity by the parent for calm responses to the child. As a result, the child experiences parental

limit-setting during the PDI phase within the context of an overall positive relationship with the parent.

- The frequency of need for use of the time-out room decreases significantly once the parent has successfully implemented the use of the room with the child. The intention of the time-out room is to help the child learn to sit on the time-out chair (initially) and to follow the parent's directives (ultimately). The time-out room is used to help the child learn to respond positively to appropriate parental leadership.
- The parent is actively coached by the therapist while implementing the time-out room procedure, so that the parent remains calm, consistent and predictable. In fact, in some cases the parent is also directly coached in managing their own emotions in the context of child discipline so that he or she can learn how to manage difficult child behavior in a safe, regulated and thoughtful manner.
- Following the use of the time-out room during the PDI phase, there is a return to child-directed interactions prior to the end of the session, in order to further calm the child and reinforce positive parent-child interactions. This is also meant to help children learn emotion regulation skills.
- Having a physical separation between parents and children is also meant to support safety. Rather than having parents and children continue to engage in conflict, the time-out space offers each an opportunity to calm down before re-engaging and solving the conflict. Some families referred to PCIT have a history of solving similar conflict with physical discipline instead of a planned time-out procedure like the one used and emphasized in PCIT.
- Under usual circumstances involving a child and staff in a treatment or care facility, blocking the door by a staff person would be considered the use of seclusion. However, the current analysis requires recognition of the following differences between the child in a treatment facility with staff alone and the child receiving PCIT in an Outpatient setting with his or her parent being coaching by the therapist:
    - The unique nature of children and families served by PCIT.
    - The carefully monitored nature of the parental intervention by the therapist to ensure safety.
    - The fact that the only person within the time-out procedure who has contact with the child is the parent – not the staff member.
    - The fact that the intervention is part of an overall manualized set of procedures.
    - The fact that PCIT could not be considered at the time that initial bulletins on coercive procedures were developed.
- Given the above considerations, the use of a separate room during the PDI phase of PCIT can be seen as involving the use of time-out and not seclusion.

- Restraint:
  - Although the PDI phase of PCIT does not involve the use of a formally endorsed restraint procedure, the parent may need to pick up the child, either to place the child in the time-out chair or to put the child in the time-out room.
  - These actions restrict the free movement of the child, and therefore technically constitute a manual restraint, even though no formally approved restraint intervention is undertaken.
  - In addition, the criteria for initiating the restraint – which involves picking up the child to move him or her from one place to another – is failure by the child to follow the parent's directive, not necessarily an emergency in which the acute safety of the child or others is at risk.
  - The previous DPW statement regarding the need for "unique implementation plans based on the needs of the children and families served and the type of services provided" is relevant in differentiating the use of restraint by staff in treatment and care facilities and the supervised use of restraint with a young child by the parent, who picks the child up and moves him or her to a time-out chair or time-out room:
    - The initial DPW definition of, and rationale for, a manual restraint was written prior to knowledge, and availability, of PCIT in Pennsylvania, and does not take into account the unique needs of children and families served and the nature of the PCIT treatment model.
    - In PCIT, the child is picked up safely by the parent, who is being coached by the therapist, and the intervention is fundamentally different than the use of restraint in a residential treatment setting or other setting involving the child and program staff. The target group for existing bulletins on coercive procedures is program staff, not parents of young children being coached by a PCIT therapist.
    - It is common and acceptable practice in society for parents of small children to pick them up on occasion to move them from one place to another, as part of parental limit-setting. This is the practice that occurs in PCIT when needed, to help a child calm down and learn to accept parental authority.
    - Through PCIT, the parent is helped to remain calm when picking up and moving a child, and is assisted in providing calm responses to the child's challenging behaviors throughout treatment.
    - The PCIT therapist is always present to ensure that the parent does not act in a physically or emotionally aggressive manner towards the child.
    - In order to function effectively in the real world, the child in need of PCIT has to learn appropriate methods of self-control. Consistent, safe use of parental limit-setting based on manual-based PCIT procedures promotes the child's and parent's self-regulation.
    - Among those who receive PCIT are many parents at risk of engaging in child maltreatment, and others who have already engaged in maltreatment towards their child. Skills gained through PCIT help the

parent to decrease the risk and likelihood of future abuse, and to be more responsive to the child's needs.

- Outcome studies involving PCIT document a decrease in child maltreatment following a completed course of PCIT. In addition, children who receive PCIT tend to be calmer and better able to maintain positive relationships.

ADDITIONAL ISSUES RAISED BY OMHSAS STAFF:

- When a child will not sit in time-out during PCIT, the time-out room is the preferred back-up method. However, there may be times when a time-out room is not available. What is to be done, when a clearly delineated time-out room is not available and a child needs to be given a time-out?
  - There are potential alternatives to the use of a clearly delineated time-out room that may be used for a child, when a clinic-based agency providing PCIT does not have a time-out room. In Pennsylvania, there is a firm requirement for PCIT that the child be able to see the parent throughout the entire time-out process. This applies when a clearly delineated time-out room is used and when alternatives are used, as described below, under circumstances where a clearly delineated time-out room is not available. Either way, child and parent(s) must have visual access to each other, when a time-out procedure becomes necessary.
  - The specific requirement is that the child be able to see the parent throughout the time-out process. It is not required, nor recommended, that child and parent have ongoing direct eye contact while the time-out process is being implemented.
  - When a clearly delineated time-out room is not available in the clinic setting, an alternative method involves a combination of what is known as the "swoop and go" intervention and the subsequent use of a door without a lock that enables the child to have visual contact with the parent.
  - With use of the "swoop and go" intervention, the parent removes all the toys and leaves the treatment room for the prescribed, time-limited interval. Thus, there is a time-out process for the child even in the absence of a clearly delineated time-out room.
  - In order to ensure visual access of the child to the parent, the provider can make use of one of the following alternatives, following use of the swoop and go intervention:
    - Have a window in the door to the treatment room, so that the child can still see the parent, who will be standing next to the door outside of the treatment room. If the door opens into a hallway, a curtain can be placed on the inside of the door, which the parent can push to the side or detach when leaving the room. As a result, the child has visual access to the parent while the parent is temporarily outside the treatment room.
    - Install a one-way mirror to the window of the door in question, so that the child can see out but no one can see in from the window. This will

enable the child to have visual access to the parent, who is standing next to the door outside the treatment room, at the same time that child and family confidentiality are protected. Use of a one-way mirror with two lit rooms will allow the child to see the parent and vice versa.

        - Use a Dutch door for the therapy room door. During the session, the entire door is closed. When the parent leaves the room following the swoop and go intervention, the top half of the Dutch door is kept open. The door should be hung to open outward. When the top half of the door is opened, it should be fastened or secured to the wall. In this way, the child continues to have visual contact with the parent, who is standing by the Dutch door outside the treatment room.
        - Dutch doors are commonly used in PCIT as part of a clearly delineated time-out room. The use of a Dutch door as an alternative to a time-out room follows the same principle as when it is used as part of a clearly delineated time-out room.
    - One final possibility, to be used as a last resort when none of the above is feasible, involves the therapist going into the treatment room with the child as the parent exits, so that the child knows an adult is still present.
    - Currently, there are agencies using PCIT in a clinic setting in Pennsylvania that have clearly delineated time-out rooms. As PCIT grows over time in Pennsylvania, it is expected that an increasing number of PCIT providers will develop dedicated time-out rooms, so that use of the alternative arrangements described above will become less necessary.
- Regarding what happens in the home, when a parent implements a time-out procedure, do Centers for Medicare and Medicaid Services (CMS) regulations, and by extension regulations in general, pertain to a parent's behavior in the home? In addition, what about the possibility that the parent will implement use of the time-out room in the home harshly, when the parent "has had enough and is at their wits end"?
    - For clinic-based services, regulations pertain to what happens during therapy sessions, which are directed and monitored by the qualified PCIT therapist. Regulations do not pertain to what takes place in the child's home during non-therapy time.
    - At the same time, however, the PCIT therapist works intensively with the parent to ensure that the parent uses the time-out procedure only when indicated, and does so consistent with the PCIT protocol, in a firm but calm manner. Both the time-out chair and, when necessary, the time-out room, are used proactively when indicated by the parent to help the child learn to self-regulate and also to enable the parent to maintain their own self-regulation.
    - Thus, while it is possible for a parent to misapply PCIT procedures at home, there is a great deal of practice and review during sessions to inform the parent how to appropriately work with the child at home.
    - In addition, PCIT teaches that the time-out room is not meant to be used over time. Instead, it is typically used within a few sessions and with tight time constraints as a tool to help the child learn how to sit on the time-out chair. Once a child learns to accept time-out on a chair, the time-out room is no longer used.

- Thus, the time-out room for a child is not intended to be used when a parent is "at wit's end," but rather to be used proactively and calmly when necessary. PCIT teaches the parent to separate from the child instead of continuing to engage in conflict. Harsh responses and even physical abuse and trauma are more likely when the parent continues to engage without having good emotional regulation, rather than when everyone (child and parent) take a "time-out." While the time-out procedure is ostensibly for the child, it also gives parents an opportunity self-regulate and then re-engage with the child when they can be neutral, calm, and safe. This is one of the reasons that PCIT has been shown to decrease the frequency of reports of physical abuse by parents (Chaffin et al., 2004; Chaffin et al., 2011).

CONCLUSION:

- Given the overall context in which the parent places a child receiving PCIT in the time-out chair and/or the time-out room, the specific needs of children receiving this treatment, the nature of the live coaching process, the focus on safety, and the time-limited nature of the child in the time-out room – and given also that both the goal and the outcome of PCIT is to decrease trauma for children – it is concluded that PCIT's procedures are permissible interventions for the target population who receive this treatment.
- Therefore, PCIT practices are compatible with existing OMHSAS policy.

References

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Parent-Child Interaction Therapy in Pennsylvania

Guidelines for PCIT Time-Out Rooms used within Pennsylvania Outpatient Clinics

Acceptable	Unacceptable
SIZE The recommended size is 5X5 or 25 square feet. It should be no less than 4X4 or 16 square feet of clear space so as not to be constricting for the child.	Small spaces < 16 sq. ft.
LIGHTING The room must be well lit. It is preferable that light switches are out of the child's reach. If they are within reach, light switches should be covered.	Dark areas.
CHILDPROOFING The room must be childproofed (e.g., electrical outlets must be removed or have childproof covers; sinks, breakable items or objects that could harm the child should be removed or contained and locked). The room should also not contain any furniture.	Spaces that contain objects that would make the area unsafe for a child.
VISIBILITY The parent is visible to the child throughout the time the child is in the time-out room.	A time-out room where the child cannot see that his or her parent is still present.
The child is visible to the parent and/or therapist throughout the time the child is in the time-out room.	A time-out room where the parent and therapist can not clearly observe and carefully monitor the child.
DURATION The use of the time-out space is time-limited. The child is physically, but not visually, separated from the parent for a brief time (1 minute + 5 seconds of quiet) before returning to the time-out chair.	Using the time-out room for extended periods of time or outside of the PCIT time-out sequence.
STRUCTURE – Separate Space When using a room as a time-out space, it is strongly preferred that a Dutch door be used between the playroom and the time-out room so that there is open air between rooms and the child can easily see the parent.	A time-out space that is not well ventilated or where the child cannot see that his or her parent is still present. A time-out space where the parent and therapist can not clearly observe and carefully monitor the child.
STRUCTURE – Within the Playroom When using a section of the playroom as a time-out space, one of the four walls defining the space must be between four feet and 5 feet, 2 inches in height. This is so the parent can easily see the child and the child can easily see the parent.	A time-out space where the child cannot see that his or her parent is still present. A time-out space where the parent and therapist can not clearly observe and carefully monitor the child.
MOVING the CHILD In getting a child to time-out chair or the time-out room, the parent (not the therapist) will guide the child.	The therapist will not place hands on a child, including that the therapist will never directly place the child in the time-out chair or time-out room.