V. Emergency Use of Manual Restraint
EMERGENCY USE OF MANUAL RESTRAINT POLICY

I. Policy

DRCC’s policy is to promote the rights of persons served and to protect their health and safety during any emergency situation including the use of manual restraints.

“Emergency use of manual restraint” means using a manual restraint when a person poses an imminent risk of physical harm to self or others and it is the least restrictive intervention that would achieve safety. Property damage, verbal aggression, or a person’s refusal to receive or participate in treatment or programming on their own, do not constitute an emergency.

II. Positive support strategies and techniques required

A. The following positive support strategies and techniques must be used to attempt to de-escalate a person’s behavior before it poses an imminent risk of physical harm to self or others:

- Follow individualized strategies in a person’s coordinated service and support plan and coordinated service and support plan addendum;
- Shift the focus by verbally redirecting the person to a desired alternative activity;
- Model desired behaviors;
- Reinforce appropriate behaviors;
- Offer choices, including activities that are relaxing and enjoyable to the person;
- Use positive verbal guidance and feedback;
- Actively listen to a person and validate their feelings;
- Create a calm environment by reducing sound, lights, and other factors that may agitate a person;
- Speak calmly with reassuring words, consider volume, tone, and non-verbal communication;
- Simplify a task or routine or discontinue until the person is calm and agrees to participate;
- Respect the person’s need for physical space and/or privacy.

B. The program will develop a positive support transition plan on the forms and in a manner prescribed by the Commissioner and within the required timelines for each person served when required in order to:
   1. eliminate the use of prohibited procedures as identified in section III of this policy;
   2. avoid the emergency use of manual restraint as identified in section I of this policy;
   3. prevent the person from physically harming self or others;
   4. phase out any existing plans for the emergency or programmatic use of prohibited aversive or deprivation procedures.

III. Permitted actions and procedures

Use of the following instructional techniques and intervention procedures used on an intermittent or continuous basis are permitted. When used on a continuous basis, it must be addressed in a person’s coordinated service and support plan addendum.

A. Physical contact or instructional techniques must use the least restrictive alternative possible to meet the needs of the person and may be used to:
   1. calm or comfort a person by holding that person with no resistance from that person;
   2. protect a person known to be at risk or injury due to frequent falls as a result of a medical condition;
3. facilitate the person’s completion of a task or response when the person does not resist or the person’s resistance is minimal in intensity and duration;
4. briefly block or redirect a person’s limbs or body without holding the person or limiting the person’s movement to interrupt the person’s behavior that may result in injury to self or others.

B. Restraint may be used as an intervention procedure to:
1. allow a licensed health care professional to safely conduct a medical examination or to provide medical treatment ordered by a licensed health care professional to a person necessary to promote healing or recovery from an acute, meaning short-term, medical condition;
2. assist in the safe evacuation or redirection of a person in the event of an emergency and the person is at imminent risk of harm.

IV. Prohibited Procedures

Use of the following procedures as a substitute for adequate staffing, for a behavioral or therapeutic program to reduce or eliminate behavior, as punishment, or for staff convenience, is prohibited by this program:
1. chemical restraint;
2. mechanical restraint;
3. manual restraint;
4. time out;
5. seclusion;
6. any aversive or deprivation procedure.

V. Manual Restraints Allowed in Emergencies

A. This program allows the following manual restraint procedures to be used on an emergency basis when a person’s conduct poses an imminent risk of physical harm to self or others and less restrictive strategies have not achieved safety:

- Please see attached the list of the allowed manual restraints that includes a description of each of the manual restraints trained staff are allowed to use and instructions for the safe and correct implementation of those procedures: Side hold, basket hold, two person escort, two person side hold, PRT, blocks, releases from wrist grab, hair pull and clothing, choke release, bite release, bear hug and weapons defense.

B. The program will not allow the use of a manual restraint procedure with a person when it has been determined by the person’s physician or mental health provider to be medically or psychologically contraindicated. This program will complete an assessment of whether the allowed procedures are contraindicated for each person receiving services as part of the service planning required under section 245D.071, subdivision 2, for recipients of basic support services or the assessment and initial service planning required under section 245D.071, subdivision 3, for recipients of intensive support services.
Conditions for Emergency Use of Manual Restraint

A. Emergency use of manual restraint must meet the following conditions:
   1. immediate intervention must be needed to protect the person or others from imminent risk of physical harm;
   2. the type of manual restraint used must be the least restrictive intervention to eliminate the immediate risk of harm and effectively achieve safety;
   3. the manual restraint must end when the threat of harm ends.

B. The following conditions, on their own, are not conditions for emergency use of manual restraint:
   1. the person is engaging in property destruction that does not cause imminent risk of physical harm;
   2. the person is engaging in verbal aggression with staff or others;
   3. the person is refusing to receive or participate in treatment or programming.

VI. Restrictions When Implementing Emergency Use of Manual Restraint

Emergency use of manual restraint must not:
   1. be implemented with a child in a manner that constitutes sexual abuse, neglect, physical abuse, or mental injury;
   2. be implemented with an adult in a manner that constitutes abuse or neglect;
   3. be implemented in a manner that violates a person’s rights and protection;
   4. be implemented in a manner that is medically or psychologically contraindicated for a person;
   5. restrict a person’s normal access to a nutritious diet, drinking water, adequate ventilation, necessary medical care, ordinary hygiene facilities, normal sleeping conditions, or necessary clothing;
   6. restrict a person’s normal access to any protection required by state licensing standards and federal regulations governing this program;
   7. deny a person visitation or ordinary contact with legal counsel, a legal representative, or next of kin;
   8. be used as a substitute for adequate staffing, for the convenience of staff, as punishment, or as a consequence if the person refuses to participate in the treatment or services provided by this program;
   9. use a prone restraint. “Prone restraint” means use of a manual restraint that places a person in a facedown position. It does not include brief physical holding of a person who, during an emergency use of manual restraint, rolls into a prone position, and the person is restored to a standing, sitting, or side-lying position as quickly as possible;
   10. apply back or chest pressure while a person is in a prone or supine (meaning a face-up) position.

VII. Monitoring Emergency Use of Manual Restraint

A. The program must monitor a person’s health and safety during an emergency use of a manual restraint. The purpose of the monitoring is to ensure the following:
   1. only manual restraints allowed in this policy are implemented;
   2. manual restraints that have been determined to be contraindicated for a person are not implemented with that person;
   3. allowed manual restraints are implemented only by staff trained in their use;
   4. the restraint is being implemented properly as required;
   5. the mental, physical, and emotional condition of the person who is being manually restrained is being assessed and intervention is provided, when necessary, to maintain the person’s health and safety and prevent injury to the person, staff, or others involved.
B. When possible, a staff person who is not implementing the emergency use of a manual restraint must monitor the procedure.

C. A monitoring form (EUMR53), as approved by the Department of Human Services, must be completed for each incident involving the emergency use of a manual restraint.

VIII. Reporting Emergency Use of Manual Restraint

A. Within 24 hours of an emergency use of a manual restraint, the legal representative and the case manager must receive verbal notification of the occurrence as required under the incident response and reporting requirements in the 245D HCBS Standards, section 245D.06, subdivision 1.

When the emergency use of a manual restraint involves more than one person receiving services, the incident report made to the legal representative and the case manager must not disclose personally identifiable information about any other person unless the program has the consent of the person.

B. Within 3 calendar days after an emergency use of a manual restraint, the staff person who implemented the emergency use must report (EUMR53) in writing to the program’s designated coordinator the following information about the emergency use:
   1. who was involved in the incident leading up to the emergency use of a manual restraint; including the names of staff and persons receiving services who were involved;
   2. a description of the physical and social environment, including who was present before and during the incident leading up to the emergency use of a manual restraint;
   3. a description of what less restrictive alternative measures were attempted to de-escalate the incident and maintain safety before the emergency use of a manual restraint was implement. This description must identify when, how, and for how long the alternative measures were attempted before the manual restraint was implemented;
   4. a description of the mental, physical, and emotional condition of the person who was manually restrained, leading up to, during, and following the manual restraint;
   5. a description of the mental, physical, and emotional condition of the other persons involved leading up to, during, and following the manual restraint;
   6. whether there was any injury to the person who was restrained before or as a result of the use of a manual restraint;
   7. whether there was any injury to other persons, including staff, before or as a result of the use of a manual restraint;
   8. whether there was a debriefing with the staff and, if not contraindicated, with the person who was restrained and other persons who were involved in or who witnessed the restraint following the incident. Include the outcome of the debriefing. If the debriefing was not conducted at the time the incident report was made, the report should identify whether a debriefing is planned.

C. A copy of this report (EUMR53) must be maintained in the person’s service recipient record. The record must be uniform and legible.

D. Each single incident of emergency use of manual restraint must be reported separately. A single incident is when the following conditions have been met:
   1. after implementing the manual restraint, staff attempt to release the person at the moment staff believe the person’s conduct no longer poses an imminent risk of physical harm to self or others and less restrictive strategies can be implemented to maintain safety;
   2. upon the attempt to release the restraint, the person’s behavior immediately re-escalates;
   3. staff must immediately re-implement the manual restraint in order to maintain safety.
IX.  **Internal Review of Emergency Use of Manual Restraint**

A.  Within 5 business days after the date of the emergency use of a manual restraint, the program must complete and document an internal review (**EUMR53**) of the report prepared by the staff member who implemented the emergency procedure.

B.  The internal review must include an evaluation of whether:
    1. the person’s service and support strategies need to be revised;
    2. related policies and procedures were followed;
    3. the policies and procedures were adequate;
    4. there is need for additional staff training;
    5. the reported event is similar to past events with the persons, staff, or the services involved;
    6. there is a need for corrective action by the program to protect the health and safety of persons.

C.  Based on the results of the internal review, the program must develop, document, and implement a corrective action plan for the program designed to correct current lapses and prevent future lapses in performance by individuals or the program.

D.  The corrective action plan, if any, must be implemented within 30 days of the internal review being completed.

E.  The Program Director and/or Senior Director is responsible for conducting the internal review and for ensuring that corrective action is taken, when determined necessary.

X.  **Expanded Support Team Review of Emergency Use of Manual Restraint**

A.  Within 5 working days after the completion of the internal review, the program must consult with the expanded support team to:
    1. Discuss the incident to:
        a. define the antecedent or event that gave rise to the behavior resulting in the manual restraint;
        b. identify the perceived function the behavior served.
    2. Determine whether the person’s coordinated service and support plan addendum needs to be revised to:
        a. positively and effectively help the person maintain stability;
        b. reduce or eliminate future occurrences of manual restraint.

B.  The program must maintain a written summary of the expanded support team’s discussion and decisions in the person’s service recipient record.

C.  The Program Director and/or Senior Director is responsible for conducting the expanded support team review and for ensuring that the person’s coordinated service and support plan addendum is revised, when determined necessary.

XI.  **External Review and Reporting of Emergency Use of Manual Restraint**

Within 5 working days after the completion of the expanded support team review, the program must submit the following to the Department of Human Services using the online **behavior intervention reporting** form which automatically routes the report to the Office of the Ombudsman for Mental Health and Developmental Disabilities:
1. report of the emergency use of a manual restraint;
2. the internal review and corrective action plan;
3. the expanded support team review written summary.

XII. Staff Training

Before staff may implement manual restraints on an emergency basis, the program must provide the training required in this section.

A. The program must provide staff with orientation and annual training as required in Minnesota Statutes, section 245D.09.
   1. Before having unsupervised direct contact with persons served by the program, the program must provide instruction on prohibited procedures that address the following:
      a. what constitutes the use of restraint, time out, seclusion, and chemical restraint;
      b. staff responsibilities related to ensuring prohibited procedures are not used;
      c. why such prohibited procedures are not effective for reducing or eliminating symptoms or undesired behavior;
      d. why prohibited procedures are not safe;
      e. the safe and correct use of manual restraint on an emergency basis according to the requirements in the 245D HCBS Standards, section 245D.061 and this policy.
   2. Within 60 days of hire the program must provide instruction on the following topics:
      a. alternatives to manual restraint procedures, including techniques to identify events and environmental factors that may escalate conduct that poses an imminent risk of physical harm to self or others;
      b. de-escalation methods, positive support strategies, and how to avoid power struggles;
      c. simulated experiences of administering and receiving manual restraint procedures allowed by the program on an emergency basis;
      d. how to properly identify thresholds for implementing and ceasing restrictive procedures;
      e. how to recognize, monitor, and respond to the person’s physical signs of distress, including positional asphyxia;
      f. the physiological and psychological impact on the person and the staff when restrictive procedures are used;
      g. the communicative intent of behaviors;
      h. relationship building.

B. Training on these topics received from other sources may count toward these requirements if received in the 12-month period before the staff person’s date of hire or in the 12-month period before this program’s 245D-HCBS license became effective on Jan. 1, 2014.

C. The program must maintain documentation of the training received and of each staff person’s competency in each staff person’s personnel record.
THERAPEUTIC INTERVENTION

Philosophy

It is DRCC's philosophy to provide training to all employees which will:

1. insure individuals are treated respectfully.
2. emphasize positive alternatives to physical intervention.
3. provide for a safer living and working environment.
4. maintain human dignity and self respect.

The overall intent of our policy is to assist all employees with developing awareness for each individual. It is difficult to quantify any human interaction, therefore, we rely on each employee's integrity to achieve the purpose of this policy.

Achieving the Intent of our Philosophy

Examples are given for each component of our philosophy and are an integral component to our training.

Insure individuals are treated respectfully
- Use courtesy words such as please, thank you, and excuse me.
- Introductions should include preferred names and titles.
- Make requests in place of giving orders and making demands.
- Give reasons for requests.
- Never tease by imitating or belittling.
- Use the same tone of voice and manner you would use with your friends and guests in your home. Be polite.
- Keep promises and don't promise something you are unable to deliver.
- Be honest and open. Earn trust.
- Avoid struggles and confrontations by deciding ahead of time if something is worth making an issue about and be big enough to give in gracefully. (No one likes being bossed around.)
- Meetings should be conducted as privately as possible and should include an explanation of the reason for the interview.
- Do not use baby talk or the word "we", (i.e., "should 'we' take a bath?"). It is both demeaning and provoking.
- Do not trick people to gain their compliance. It is unethical and does not build good relationships.

Emphasize positive alternatives to physical intervention
- It is important to remember you cannot make anyone do anything, therefore, threatening is unproductive and can cause escalation/injury.
- Human emotions can fluctuate daily; to have successful relationships, we must be flexible.
- It is important to be aware of the level of stress.
- The goal is to de-escalate; calm behavior can accomplish this goal.
- Be aware of the nonverbal messages you give. People tend to believe messages they see rather than hear because nonverbal clues may be harder to fake.
- Gentle touch can be a valuable tool for conveying comfort and compassion. However, be aware of individual preferences. Sometimes asking before touching will be a good indicator of how it will be received.
- Finally, ask yourself, is the issue or situation really worth a physical confrontation

Provide for a safer living and working environment
- It's important to remember that the actions taken during a stressful encounter not only impact the client, but may affect the safety of yourself and others.
- Be aware of the environment; a violent episode which occurs in a place where potentially dangerous weapons are kept (kitchen knives) is not a safe environment. Removing yourself and other clients away from the situation or violent client is completely acceptable.
- Many instances of aggression are predictable. Be aware of situations or activities which provoke agitation.
- Practice your responses towards an individual who is appearing agitated. You will be better prepared when a situation arises.

**Maintain human dignity and self-respect**
- Always knock and wait for an answer before entering a person's bedroom.
- Respect and protect clothes and property.
- Maintain a comfortable "talking distance" when conversing with people.
- Recognize the necessity for privacy for bathing, dressing, and performing other grooming activities.
- Unless an urgent reason exists, bathrooms, showers, and toilets should not be entered when in use. If the area must be entered for protection, knock and announce your intention prior to opening the door.
- Recognize and promote opportunities to meet individual needs for solitude and reflection.
- Whenever possible, allow choices of housemates and assist in working out arrangements for privacy and personal space.
- Encourage people to have and display personal possessions and pictures.
- Each person should have adequate space to store clothing and possessions.
- Emphasize similarities rather than differences between you.
- Acknowledge and show respect for each person's lifestyle.
- Be considerate and polite with a person's family and friends.
- Use effective communication techniques, such as active listening and "I" messages.
- Assist the individual as necessary in being well-groomed and appropriately dressed.
- See that clothing is attractive and well-fitted. Unattractive clothes do not enhance self-esteem.
- Labeling will decrease dignity and self-esteem and can produce negative expectations which may become a self-fulfilling prophecy.
- Anticipating needs can help people avoid having to ask for things. Always having to ask can be demeaning.

It is possible that positive therapeutic strategies may not work. In order to protect an individual from hurting themselves and/or others, emergency use of manual restraints may need to be implemented.
Supportive Stance

Stance- non intimidating, be supportive, don’t box someone in.

Reasons for using the Supportive Stance:

1. Staff safety and escape routes
2. Nonthreatening/nonchallenging
3. Shows respect for personal space

Angle body-leg length away and off to the side.

Block and Move

Be in Supportive Stance, both hands up and move out of the way. Give verbal ques-calm down, it’s o.k.

Kick Block

Turn leg up/hands up and to the side to protect chest and move away. (Heisemen Trophy)

In any strike situation, you can remove the target or deflect the weapon by placing an object between the weapon and the target. The act of blocking or shielding is based on your natural response— a primal reflex to protect yourself from a strike. In this example, the bottom of the staff member’s foot is used to shield or block the oncoming kick.

Attempt to move out of the way to maintain safety.
One-Handed Wrist Grab

Supportive Stance- go to persons outside by bending elbow, YELL- let go or stop to distract them. (Small wrists use other hand to help pull hand through and use a smaller stance.)

Gain a physiological advantage by using leverage and momentum to pull away from the weak area of the wrist grab (between the thumb and four fingers). You can increase your momentum and leverage by maintaining a balanced stance and using your body position to enhance your physiological advantage. At the same time, you can gain a psychological advantage by using a verbal distraction or an element of surprise.

Release and attempt to move out of the way to maintain safety.

Two-Handed Wrist Grab

Supportive Stance- verbal ques, bend held arm at elbow then turn at hips and turn out.

If you need more momentum and leverage take your free arm and bring it in and over to grab your grabbed hand then turn at hips and turn out.

If thumbs are down- still elbow down.

Gain a physiological advantage by using leverage and momentum to pull away from the weak area of the wrist grab (between the thumb and four fingers). You can increase your momentum and leverage by using your free hand to assist in pulling away from the grab, maintaining a balanced stance and using your body position to enhance your physiological advantage. At the same time, you can gain a psychological advantage by using a verbal distraction or an element of surprise.

Release and attempt to move out of the way to maintain safety.
One-Handed Hair Pull
(One-Handed Clothing Grab-Same)

Secure flat part of hand by using one or both of your hands. Move in on the person- it makes their elbows bend; tuck your head causing their hand to bend, and then pull back.

Two-Handed Hair Pull

Put both your hands over the person's hands covering them. Move in one the person and angle toward their hip (side) this will bring in their elbows. Then pull down.

Two-Handed Clothing Grab

Turn body-hands over hands, slide hands down as you are turning away.

Slide one hand over and under theirs in a snake like motion then pull away

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Immobilize this grab by securing the person's hand to your head. By using one or both of your hands to immobilize the person's hand, you can prevent further grabbing of hair and minimize injury. Move your head toward the person, leveraging the arm position to a 45-degree angle. The grip of the hair pull is levered backward, reducing the strength of the grip and opening up the weak point of the grab at the fingers. At the same time, you can gain a psychological advantage by using a verbal distraction or an element of surprise.

As your hair is released, attempt to move out of the way to maintain safety.

Use both of your hands to immobilize the person's hands on your head. By securing the hands to your head, you can prevent further grabbing of hair and minimize injury. Move your head toward the person, leveraging the arm position to a 45-degree angle. The grip of the hair pull is levered backward, reducing the strength of the grip and opening up the weak point of the grab at the fingers. At the same time, you can gain a psychological advantage by using a verbal distraction or an element of surprise.

As your hair is released, attempt to move out of the way to maintain safety.
**Front Choke Release**

Widen stance, stay calm, and throw arms straight up lean back (it straightens their arms). Gain momentum by rotating arms in a rotating motion.

Raise your arms straight up for leverage. (This may also create a distraction.) Lean away to extend the individual's arms; this will weaken the grab. Create momentum by turning your shoulders and arms in a rotating motion away from the individual. Your shoulders will act as a lever while your momentum will assist in releasing the grab. Increase your psychological advantage by using a verbal distraction or an element of surprise.

Attempt to move out of the way to maintain safety.

**Back Choke Release**

Widen stance- arms straight up in air, lean forward rotate, turning away from person.

Raise your arms straight up for leverage. (This may also create a distraction.) Lean away to extend the individual's arms; this will weaken the grab. Create momentum by turning your shoulders and arms in a rotating motion away from the individual. Your shoulders will act as a lever while your momentum will assist in releasing the grab. Increase your psychological advantage by using a verbal distraction or an element of surprise.

Attempt to move out of the way to maintain safety.
Bite Release

Push in arm, move other hand in to vibrate upper lip, then roll down and out.

Other body parts: Support head then push in and roll out.

Strangle Hold Release
(forearm across the throat)

Turn head into their elbow, push up on their elbow and their wrist then drop to the floor.

Head Lock Release

Turn your head into their body, put one hand on their elbow and one on their back and push forward.
Bear Hug Release

(Back)
Over the arms: Flip arms up like a chicken and drop to the floor.

Under the arms: Finger peel, knuckle knocking, grab wrists, pushdown lifting yourself up.

(Front)
Over the arms: Turn from side to side and allow weight to drop you to the ground.

Under the arms: Bring your arms around under the individual’s arms. Put your hands between your body and the individual’s body, make fists, push your knuckles into his/her sternum as you are pushing away from him/her. You may need to do the process repeatedly until it is effective.

Weapons Defense

Staff should not attempt to take a weapon away from the person. Weapons could be a knife, chair, dish wrack, fry pan, anything a person can pick up and hurt someone with. If another client is around get them out of the area. Staff should get away from the person, if needed pull furniture into the person’s path increasing your protection and slowing them down. Most important is to get away.

Pull Through

Pull Through- Start with outside block, keep outside of the punch, block with which ever hand they are punching with. Then wrap your hand around their forearm and pull while your other hand goes to their shoulder as a guide, and then pull the person through.
Basket Hold

In order for this to work you should be:
- A head higher than the individual
- Stronger than they are
- Can get your arms around them

You start with the “Pull Through” then bring your other hand across their back and guide the other arm toward your other hand switching their hands then cross their elbows at the chest level. Then turn your body, lean them back into you putting your foot back lean in to the person with your shoulder. (Try to pivot on one foot.)

This hold is designed to be used with children. You could use this position only with individuals considerably smaller than yourself.

Gain control of the person’s arms from behind and cross the arms in front of the person. The arms should be positioned high on the person’s upper chest and secured by locking one arm under the other. This will prevent the person from slipping through and will minimize any pressure on the person’s chest or abdomen. Position yourself behind the person while maintaining close body contact and standing to one side. This position allows you to maintain a balanced stance while managing the person. The auxiliary team member(s) will monitor for safety and assist, if needed.
Two Person Side by Side Escort

Stand to the sides of the person to be escorted. If on right side, use right hand to grasp right wrist area. If on left side, use left hand to grasp left wrist area. Turn wrists so palms face up. With opposite hand grasp the same arm above the elbow. While pulling person towards you, place the person between the hips of both staff. Walk at a moderate pace to a designated area.

If the person being escorted is not adequately controlled using the above procedures, the following may also be done to increase control. The staff person on the left of the person being escorted can move their right hand from the upper arm, behind the back to the right forearm of the person being escorted, while continuing to hold the left wrist in their left hand. This staff person should use their right to pull the person being escorted closer to their hip. The staff person on the right of the person being escorted should do the same by moving their left arm from the upper arm, behind the back to the left forearm. This staff person should use their left hand to pull the person being escorted closer to their hip.

Two Person Take-Down

This procedure should be used only after less intrusive techniques have failed. Staff should implement a take-down if a person is actively resistive and aggressive with the possibility of causing injury to themselves or others, and if staff determines these dangerous and threatening behaviors would continue if a take-down was not used.

From the basic escort position, both staff should turn toward the person being escorted until they are facing the opposite direction. Reverse the direction of the escort while gently bumping the person behind the knees, using your legs as leverage to keep the persons legs from moving rearward. Ease the person to the floor on their back by kneeling as you bring the person down, keeping hold of their arms. Use inertia and leverage to place the person as safely as possible in a supine hold position.

Supine Holding Position

Each staff person will be responsible for holding a specific body area. Use grasps obtained during the take-down, your own body weight, and non-painful leverage as necessary to maintain the person in a safe supine position. The ideal supine holding position is arms at the side, palms down, with legs held extended straight. Supine holding position is ideal for three or more staff but in some situations may be possible to restrain using two staff. With three staff, use one staff on each side of the upper body and one staff on the lower body. With two staff, one staff might hold both arms and the second staff may straddle the legs. All staff involved should gradually release pressure as the person cease struggling and relaxes, being ready to increase pressure if the person starts struggling again.