

# RESIDENTIAL GROUP CARE QUARTERLY

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## Achieving Better Outcomes for Children and Families: Reducing the Use of Restraint and Seclusion

By Katherine Johnson

In September 2001, when the Substance Abuse and Mental Health Services Administration (SAMHSA) funded the Child Welfare League of America (CWLA), in partnership with the Federation of Families for Children's Mental Health, as the Coordinating Center for the Restraint and Seclusion Training Grant, we viewed ourselves as experts in the field of behavior support and intervention. After all, we were familiar with the dangers associated with restraint and seclusion, had participated in forming the language of the Children's Health Act of 2000, and had just published the CWLA Best Practice Guidelines in Behavior Management. But in spite of our experience, none of us could have guessed how much we were to learn in the next three years.

In 2001, we already had a thorough understanding of the risk involved with the use of restraint and seclusion. The *Hartford Courant* series had documented 142 reported deaths in the previous decade as a result of restraint and seclusion (Allen, 1998). Twenty-six percent of those deaths involved children—nearly twice the proportion children

constitute in mental health settings.

We were also aware of the adverse psychological effects associated with restraint and seclusion. Children and adolescents who have been restrained in psychiatric hospitals report painful memories and fearfulness at seeing or hearing others being restrained and a mistrust of mental health professionals (General Accounting Office, 1999). It was clear to us that the long-term, negative consequences of restraint and seclusion far outweighed any short-term benefits gained by their use, except in situations posing imminent danger to either consumers or staff members.

We also knew that training alone, without the support of leadership and a shift in organizational culture, would not significantly reduce numbers of emergency safety interventions; thus, we immediately changed the name of the grant from the "Restraint and Seclusion Training Grant," to the "Best Practices in Behavior Management Project: Preventing and Reducing the Use of Restraint and Seclusion."

In 2003, we changed the project's title again, this time to "Best Practices in Behavior Support and Intervention:

### INSIDE

#### Star Project Outcomes

Brewer-Porch Children's Center minimized restraint and seclusion with staff development, changes to children's environments, and debriefing following interventions, among other approaches. —Page 3

#### The Devereux Glenholme School

Through activity-based and milieu therapy, the school reduced its reliance on reactive responses. —Page 6

#### Lessons Learned

Klingberg Family Centers takes a three-year retrospective look at the result of changes to reduce restraint and seclusion. —Page 8

#### What a Difference a Grant Can Make

The Methodist Home for Children and Youth makes major changes thanks to a SAMHSA restraint and seclusion grant. —Page 10

#### Courageous Patience

Connecticut's Riverview Hospital looks closely at program philosophy, milieu redesign, and leadership to make key changes. —Page 12

#### Best Practices: A Partnership

Girls and Boys Town partner with Jessie Polinsky Children's Center to implement a better system of care. —Page 14

#### Point/Counterpoint

Should all organizations that provide training for behavior support and crisis management be required to use a certified model? —Page 17

# RESIDENTIAL GROUP CARE QUARTERLY

Volume 5, Number 2

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Preventing and Reducing the Use of Restraint and Seclusion." This final change reflected our belief that for behavior to be truly managed, it must be managed by the individual with the support of skilled caregivers. The evolution of our project name in many ways reflected our advancement of knowledge regarding successful interventions to reduce restraint and seclusion.

Despite our awareness from the outset that training alone would not sufficiently reduce restraint and seclusion, we did not realize the degree of commitment required to successfully reduce emergency safety interventions. The project taught us a number of things:

- Agency leadership must model a sustained commitment to any reduction initiative.
- Organizational culture must reflect a client-centered environment and focus on relationship-building.
- Comprehensive agency policies and procedures must be in place to emphasize reducing restraint and seclusion.
- The treatment milieu must demand safety while providing a predictable environment.
- Strong continuous quality improvement processes must be in place.

These lessons were not easily learned but have been invaluable as we have begun disseminating our findings to community-based residential treatment facilities, psychiatric treatment facilities, and hospitals committed to reducing restraint and seclusion among the youth they serve.

The following articles seek to provide more detailed information regarding the interventions instituted by each demonstration site involved in the Best Practices in Behavior Support and Intervention Project. CWLA's hope is that you might benefit from the lessons we have learned to reduce restraint and seclusion in behavioral health settings nationwide. The safety and well-being of our children and staff members depend on it.

## References

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# STAR Project Outcomes

By Nancy Campbell

Brewer-Porch Children’s Center (BPCC) named its SAMHSA project “Staff Training and Resources” (STAR). As the name suggests, staff development was a major focus, but not the only one.

A mental health treatment center and teaching clinic of the University of Alabama, BPCC is located on a 54-acre campus near the school’s main campus in Tuscaloosa, Alabama.

Serving children and adolescents who meet Alabama’s criteria for severe emotional disturbance (SED), BPCC employs approximately 225 staff members—primarily direct-care paraprofessionals—and offers services across six programs, with a total capacity of approximately 140.

Data on the use of containment (i.e., restraint) were collected across all six programs and coded primarily from Crisis Intervention Reports (CIRs), the agency’s clinical documentation of use of containment and seclusion. Seclusion data were collected in the three programs in which seclusion is permitted by policy.

Specific STAR outcome measures cluster roughly into three groups:

- duration (length) of intervention,
- frequency (number) of interventions, and
- quality of interventions (spanning safety-related measures as well as staff compliance with policy).

Each group of measures yielded noteworthy findings.

## Duration

BPCC staff keep interventions short. This finding is consistent with STAR project goals and center policy that staff employ containment and seclusion only as long as necessary to contain dangerous behavior, ending the interventions as quickly as safely possible

to focus instead on debriefing with youngsters and helping them rejoin ongoing programming.

From January 2002, through March 2004, the period for which data analyses were available at the time of this report, duration of containment averaged three minutes. Modal duration, the single most frequent duration reported, was one minute. Median duration, the dividing point between the longer 50% and shorter 50% of interventions, was two minutes. Calculations of average duration at six-month intervals reflected an overall pattern of declining duration as the STAR project progressed.

Average duration of seclusion for the same period was 12 minutes (mode = 5 minutes or less; median = 8 minutes). Average duration at six-month intervals as the project progressed reflected an overall decline in duration of seclusion.

## Frequency

Data vary by intervention and program, but with one exception programs either consistently maintained low rates of interventions or significantly reduced use of the interventions.

Three programs, located primarily in off-campus settings, maintained low

frequencies of containment throughout the baseline (2000–2001) and project periods:

- The Adolescent Adaptive Skills Training Program—a school-based program for middle and high school students, similar to day treatment interwoven throughout the school day—consistently averaged less than one containment per month.

- The Community Autism Intervention Program, which places specially trained behavioral aides to work with children in their public school settings, reduced its monthly average from three during baseline to two in 2002 and less than one during 2003.

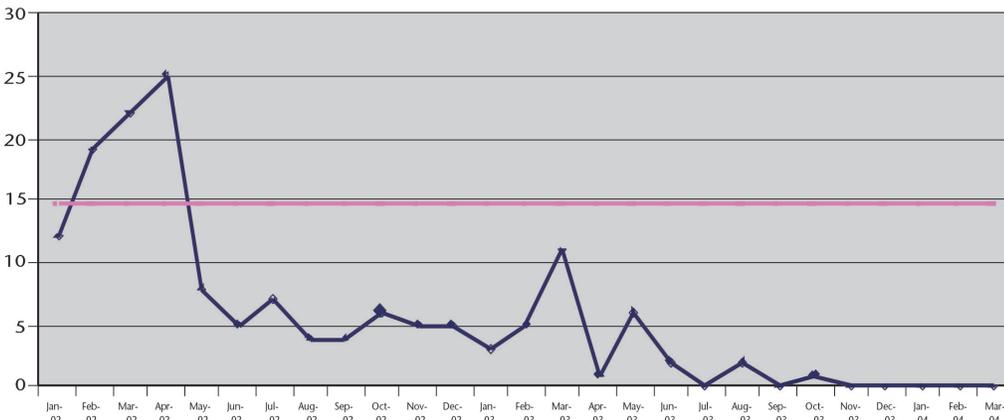
- Therapeutic Foster Care progressed from an average of less than one per month during baseline and 2002 to none in 2003.

These three programs do not employ seclusion.

Figures 1 (below) and 2 (page 4) illustrate project data for the Short-Term Treatment and Evaluation Program (STTEP), a secure, 10-bed, diagnosis-and-evaluation unit also employed for crisis stabilization. Maximum length of stay is 90 days.

After a short-lived increase above baseline rates early in 2002, STTEP

Figure 1: Brewer-Porch Physical Restraint, January 2002–March 2004



made steady progress in reducing both containment and seclusion. The horizontal lines represent the average number of interventions per month during baseline (2000–2001); the irregular lines indicate frequency of use each month during project implementation (2002–2004).

The most striking result is that STTEP staff achieved a restraint- and seclusion-free environment in four of the six months between November 2003 and April 2004 (April not shown in Figures 1 and 2) in an acute-care environment that has a relatively rapid turnover of clients.

Residential Treatment, a 20-bed program providing longer-term residential care (average stays lasting approximately one year), reduced interventions significantly in the first year of the STAR project. Compared with the baseline monthly averages of 49 containments and 54 seclusions, the 2002 monthly averages were 18 and 16, respectively.

In contrast, 2003 monthly averages for containment increased to 31 while seclusions increased to 38. Significantly lower average monthly rates have again been achieved during the first quarter of 2004, at 21 containments and 29 seclusions.

The increased rates in 2003 are somewhat attributable to client acuity, but are mostly due to changes in the children’s environment in residential treatment—some planned, some unavoidable.

Early in the year, BPCC changed the practice of assigning residents to coed cottages by age and developmental maturity, assigning them instead on the basis of gender alone. In retrospect, it was evident that planning had been inadequate to accommodate the logistics and changes in peer dynamics that occurred when children of the same gender but widely varying levels of maturity were housed together.

Unavoidable stressors affecting the residential treatment on-campus school milieu included changed classroom dynamics following the replacement of a retiring long-term teacher with a new teacher, and the near-simultaneous and unexpected termination of several children’s public school placements (initiated to help prepare them for upcoming discharge back into the community), which was highly disappointing and frustrating for the youngsters.

Outpatient Day Treatment (ODT), which serves 32 elementary school students—eight in each of four classrooms—who require a more restrictive

***STTEP staff achieved a restraint- and seclusion-free environment in four of the six months...in an acute-care environment that has a relatively rapid turnover of clients.***

environment than available in local public schools, is the only program that has had mixed results during the implementation of STAR. Overall, ODT’s rates of interventions have remained at approximately the same level as their average monthly baseline rates of 37 containments and 31 seclusions.

A statistical summary may be misleading, however, in that individual classroom outcomes vary widely. Specifically, there were progressive reductions in rates of use in one classroom, fluctuating levels in two classrooms, and overall increased rates in the other.

### Quality of Interventions

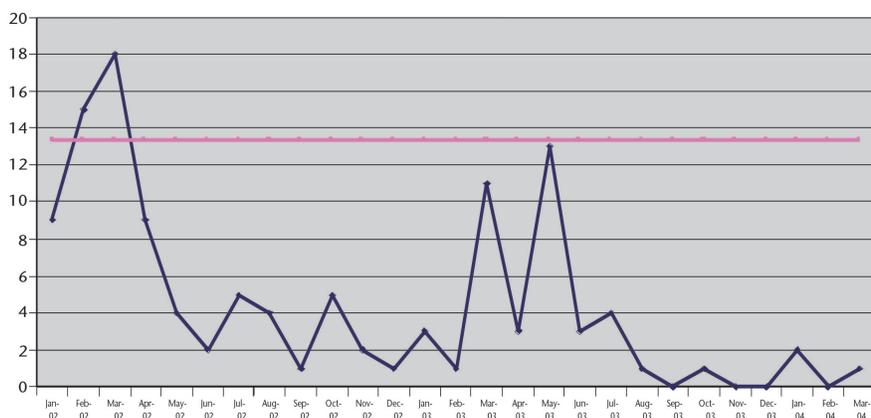
BPCC employed a number of measures in evaluating quality of interventions. For example, documentation on CIRs of monitoring of clients during interventions consistent with policy averaged 95% for 2002, 93% for 2003, and 97% for 2004 (through March).

Documentation of debriefing with youngsters following interventions consistent with policy averaged 96%, 96%, and 99% for the same three periods, respectively.

And documentation of program coordinator review of CIRs consistent with policy averaged 93%, 94%, and 95% for the same periods, respectively.

Injuries to youngsters during a restraint or seclusion averaged 1.5 per month across BPCC. The project

**Figure 2: Brewer-Porch Physical Seclusion, January 2002 to March 2004**



director reviewed all relevant documentation and interviewed staff and supervisors to assign severity ratings on a four-point scale; all were Level 1—minor injuries that required, at most, first aid.

Documentation on CIRs of post-assessment of youngsters (pending arrival of a licensed independent practitioner for face-to-face assessment) ranged from 24% in 2002 to 68% in 2003 (following revision of the CIR form mid-year to correct design flaws and subsequent staff training in use of the revised form) to 97% in 2004—thus illustrating how data were used to foster performance improvement.

### Successful Interventions

Three changes appeared to contribute most to STAR's success:

- New, more stringent policies were implemented regarding the use of containment and seclusion, consistent with new Alabama Department of Mental Health and Mental Retardation regulations in January 2002, which coincided with the first month of project implementation.

- BPCCC established a professional training department with two full-time staff trainers. Before this, training was conducted as added on responsibilities of other staff. The new full-time trainers retrained all BPCCC direct care and professional clinical staff within the first six months of the project—for a total of more than 2,000 training contact hours—in a new model of crisis management that emphasizes verbal deescalation (Satori Alternatives to Managing Aggression, or SAMA).

- Some 25 staff members from varied levels of supervisory responsibility across all program settings underwent 8½ days of supervisory training, using Parts I and II of CWLA's *Effective Supervisory Practice* curriculum and its new *Behavior Support and*

***Although physical safety risks for staff and youngsters, and risks of traumatization for children and youth, were emphasized from the beginning, the sheer stress staff felt while implementing containment and seclusion had not received as much attention.***

*Intervention for Children and Youth* curriculum.

Many other interventions also contributed to project success—for example, expanded coverage of risk factors and consumer perspectives in restraint and seclusion classes; revamped orientation for new employees, and annual training classes for all staff; more explicit and flexible parental consent related to use of containment and seclusion; expanded assessment of relevant risk factors at referral and intake; and program- and population-specific expert consultation.

### Challenges

Some of the greatest challenges were posed by the limited time frame for the project and consequent time pressure, competing priorities, and the rapid pace of change. Some initiatives were very demanding of staff time and energy; others with promise were difficult to sustain—for example, making incident reviews by teams of staff routine.

Another significant challenge was the relative youth and limited supervisory experience among program coordinators—hence the emphasis on supervisory development). BPCCC also had a relatively limited number of LIPs

at project inception to consult on interventions, which created logistical problems and stress.

Other challenges, in the form of inertia and skepticism, which seem inherent to almost any change process, appeared intermittently. The greatest systems challenge was difficulty engaging education staff and clinical/residential staff to work proactively and cooperatively as needed, although progress was made and, at times, excellent.

### Doing It Differently

Mid-project, STAR began incorporating more staff perspectives into training and related discussions. Although physical safety risks for staff and youngsters, and risks of traumatization for children and youth, were emphasized from the beginning, the sheer stress staff felt while implementing containment and seclusion had not received as much attention. The project would have probably progressed more quickly and smoothly had this emphasis been present from the inception of the STAR project.

*Nancy Campbell PhD, is STAR's Project Director.*

# The Devereux Glenholme School

By Mary Guilfoile

Nationwide, providers are responding to external forces to eliminate restraint and seclusion by focusing on proactive, preventive interventions.

This focus corresponds to the Devereux Glenholme internal quality improvement process. Through activity-based and milieu therapy (a rich menu of activities that includes the arts, athletics, technology, equestrian, nature studies, and social clubs) we have been able to reduce the need for reactive responses.

A center of the Devereux Foundation, Devereux Glenholme is located in the foothills of the Berkshires in Washington, Connecticut. The school's 95 students, ages 5–17, have a variety of psychiatric diagnoses and display emotional and behavioral problems. They require 24-hour supervision; a therapeutic milieu; individual, group, and family therapy; and transition planning services. All students attend an on-grounds special education school. Boards of Education and the child welfare system are the major referral sources. Devereux Glenholme's students are 81.3% white, 5.4% Hispanic, 5.4% African American, 3.2% Asian American, and 4.3% other.

Devereux Glenholme employs 142 staff members in a variety of disciplines, including clinical social workers, certified teachers, behavior specialists, support personnel, and others. The target of our Best Practices in Behavior Support and Intervention grant from SAMHSA were 44 supervisory and direct-care staff members who provide a therapeutic and instructional milieu in morning, evening, and weekend programming. The educational criterion for these positions is a bachelors degree in psychology, recreation therapy, or a related field.

In the period preceding grant implementation, older children, ages 12–18,

## *Children prepared themselves for naturally occurring triggers in the regular program by learning new coping strategies and their benefits*

were less likely than younger children, ages 6–11, to be involved in a restraint or seclusion. One of the target areas for the grant was enhanced training so staff might better understand the needs of the younger population and the refinement of treatment techniques for this group.

### **Enhancements to Training**

The grant allowed us to add computer-based options to the blended instructional model used during orientation. Six learning modules introduced vocabulary and concepts and tested users' knowledge. Three problem-solving simulations challenged participants to apply concepts in case scenarios. The modules and simulations were customized to reflect Devereux Glenholme School's philosophy, values, policies, procedures, and practices.

### **Positive Behavior Supports**

The faculty conducted active research in positive behavior supports, a problem-solving approach to managing problem behaviors by matching support strategies to the needs of the student to reduce or eliminate the targeted behavior. This can be achieved through procedures that

- change the environment to make the behavior irrelevant,
- teach appropriate behaviors to make the problem behavior inefficient, and
- manipulate the consequences to

ensure appropriate behaviors are more consistently and powerfully reinforced than are problems behaviors.

This project matched known effective positive behavior supports for elementary, middle, and high school students on the basis of intellectual and social functioning. It described the context and circumstances under which selected positive behavior supports are effective and also developed systems to highlight needed supports as soon as possible after enrollment. A pilot profile for a targeted group of children was scheduled to begin in September 2004.

### **Antecedent Control Strategy**

Many of our younger children display impulsive, reactive behaviors that are difficult to manage solely through the use of consequences (acceleration or deceleration techniques). Antecedent control strategy identified the environmental and interpersonal triggers for extreme misbehavior.

These antecedents were initially controlled through environmental change (changed settings, tasks, groups, expectations, and so on). After a period of stabilization and reduction of maladaptive behavior in an altered environment, children prepared themselves for naturally occurring triggers in the regular program by learning new coping strategies and their benefits.

This strategy was implemented with a pilot group of three highly aggressive, assaultive 8- to 10-year-olds, a 13-year-old with chronic elopement behaviors, and a 9-year-old with extreme self-injurious behaviors. This strategy differed from instructing children in replacement behaviors—it focused adult attention and data collection on the specific antecedents within the environment that needed to be regulated.

## Outcomes

**Computer-Based Learning.** Computer-based learning options reached 72 residential staff. Surveys were conducted with 86% of participants. Both content-specific modules and problem-solving simulations were rated very helpful (94% and 99%, respectively). All participants found the content to be very important.

The e-learning format met the needs of a variety of learners, allowing for self-paced, individualized instruction based on skill level, and ongoing tracking. Classroom dialogue was enhanced, as all participants were familiar with the vocabulary and concepts. Instructors were able to use face-to-face classroom time for case studies and practice, a primary goal for implementation.

**Positive Behavior Support.** At one time in Devereux Glenholme's history, school was the least frustrating time of

day for youngsters. But this is no longer the case for most of the older students who have histories of school failure, or for younger students who are less likely to have student skills' because of multiple school placements and inconsistent attendance. The Positive Behavior Support project has expanded the repertoire of interventions for these students.

**Antecedent Control Strategies.** In all cases, when the environment was altered to eliminate antecedents, the problem behavior was either eliminated (elopement) or dramatically reduced (aggression, self-injurious behavior). The results during the reintegration phase were favorable, with fewer incidents than during pre-intervention. The most dramatic result was to decrease on-campus elopement from 14 instances in four weeks to two instances in two weeks.

A great challenge has been refining data collection to accurately reflect the

problematic times, events, and issues in the environment. There is an ongoing need for accurate, objective reporting. Another challenge is the faithful implementation of new techniques that may be unfamiliar to the direct-care and supervisory staff who must carry them out. The participation of senior management in the oversight and monitoring of pilot projects has been essential.

*Mary Guilfoile is Director of Training and Development, Devereux Glenholme School Washington, Connecticut.*

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# Lessons Learned in the Reduction of Restraint and Seclusion: A Three-Year (Plus) Retrospective

By Steven A. Girelli

Like hundreds of multiservice child welfare agencies across the country, Klingberg Family Centers started as an orphanage, opening its doors roughly 100 years ago. About 30 years ago, we transitioned into a residential treatment center. Now we maintain a variety of programs in addition to residential treatment, including special education, day treatment, emergency shelter, foster care and adoption, family preservation and reunification, and a host of others. But it's in the residential treatment center that we serve the most challenging and vulnerable population, and where the frequency and possible misuse of restraint and seclusion is greatest.

Klingberg's residential treatment center serves children and adolescents suffering from family discord, emotional disturbance, and psychiatric illness. We serve kids referred from hospitals, shelters, schools, and other treatment centers. We serve an increasingly acute group of youth, and we think we do it very well.

And when our restraint and seclusion data run high, we think it's because we serve the most difficult children in the state, possibly the whole country—not unlike the thoughts running through the minds of many other providers like us. We tell ourselves that those places that have reported being so successful at reducing or even eliminating restraint and seclusion must be working with the easy kids. Or have much better staffing ratios. Or overuse medication. Or fudge their data.

For years, these rationalizations kept us from making meaningful progress in our attempts to reduce our reliance on invasive behavior management techniques. In fact, they still present a tempting foil when our efforts become frustrated or frequencies start to climb.

***For years, rationalizations kept us from making meaningful progress in our attempts to reduce our reliance on invasive behavior management techniques. In fact, they still present a tempting foil when our efforts become frustrated or frequencies start to climb.***

Nonetheless, over the past several years, Klingberg has seen a meaningful and, so far, lasting reduction in restraint and seclusion. Several factors seem to account for this improvement—but there is no empirically convincing way to establish which factors had the greatest impact. None is likely to succeed in isolation.

A critical underlying theme has been the intentionality with which we have approached the goal of reducing restraint and seclusion. This intentionality is reinforced through repeated expressions of an organizational commitment to reducing restraint and seclusion.

Like so many other providers nationwide, we were devastated by the *Hartford Courant's* exposé on restraint and seclusion deaths. We reacted with denial, anger, incredulity, resignation, and finally, determination. Reducing restraint and seclusion, while always an organizational goal, took on tremendous import. It became a central topic in many internal meetings. It fueled collaborations with other providers, associations, and regulators. And it became a yardstick through which we continue to measure our organizational self-worth.

This intentionality has been manifested in several ways. In response to changing regulation, accreditation requirements, and emerging best practices, we modified our policies and procedures to restrict the use of restraint and seclusion, while we increased administrative and clinical oversight and enhanced monitoring practices. In essence, we simply legislated reductions in our use of restraint and seclusion. These changes also reinforce an organizational commitment to reducing restraint and seclusion.

Shortly following the *Courant* series and subsequent discussions among state and federal legislators, we joined with other providers and CWLA to pursue a commitment to enhancing staff skills as a primary tool in reducing the need for restraint and seclusion. This very act was one expression of organizational commitment. Our successful pursuit of the federal SAMHSA grant with the other members of the Connecticut Collaboration for Training

Excellence provided much-needed resources and communicated an organizational commitment to reducing restraint and seclusion.

With SAMHSA funds, we made a number of improvements. One has been a tremendous enhancement in the training we provide our entire direct-care workforce. Staff undergo more and better training, using new and improved curricula that stress the importance of training in a range of knowledge and skills, rather than focusing on behavior management as a primary skill area. To this effort we have imported new training resources and invested in the breadth and skill of our training personnel. Not only has this training increased knowledge and skills, it has communicated an organizational commitment to reducing restraint and seclusion.

***Not only has the training increased knowledge and skills; it has communicated an organizational commitment to reducing restraint and seclusion.***

Increased training has served the added function of instilling in our direct-care workforce the notion that they are professionals. The development of a career ladder for our child and youth workers has greatly advanced this effort. Under the new advancement system, these staff may progress through three levels of child and youth work, based on education, experience, documented competence, and acquired skills.

This system has allowed us to recognize and reward excellence, advancing skills, and growing professionalism. It has also helped us develop a cadre of staff who can share their expertise by providing training to their colleagues, thus expanding our still-limited training resources. And it has communicated an organizational commitment to reducing restraint and seclusion.

Though not motivated by our desire to reduce restraint and seclusion, per se, another programmatic change has been a tremendously influential factor. Some two years ago, we began a transition in our Acute Residential Unit, away from a cognitive-behavioral milieu model and toward a relational model. As part of this transition, we eliminated all vestiges of a point and level system and taught staff to recognize their relationships with the clients as their most potent therapeutic tool.

This has led to a number of positive outcomes, among them a reduction in restraint and seclusion in that unit disproportionately greater than the reductions evidenced in our other units. Although many factors could contribute to this disproportionality (for example, population acuity, staff abilities, and staffing ratios), we are convinced the change in milieu approach has been a decisive factor. Evidence for the contribution of this milieu change comes in part from the overwhelmingly positive feedback from clients and their families.

We are convinced none of these initiatives alone could have demonstrably affected our use of restraint and seclusion. In the aggregate, however, they have resulted in an 80% reduction in the frequency of

restraints and somewhat higher reduction in the frequency of seclusions over the past five years. Inasmuch as restraint and seclusion are complicated and determined by many factors, the need for a comprehensive, multidimensional approach to their reduction seems obvious.

***The new advancement system has allowed us to recognize and reward excellence, advancing skills, and growing professionalism.***

But we shouldn't underestimate the symbolic significance of these interventions in articulating and reinforcing to the entire organization a commitment to addressing our reliance on restraint and seclusion. This organizational commitment has been a crucial factor in the successes we have made to date.

*Steven A. Girelli PhD, is Vice President, Quality Enhancement and Staff Development, Klingberg Family Centers, and Project Director, Connecticut Collaboration for Training Excellence.*

# Lessons Learned and Organizational Changes Implemented as a Result of the SAMHSA Restraint and Seclusion Grant

By Michael J. Budlong

The Methodist Home for Children and Youth is a multiservice child and family agency serving children and youth throughout Georgia. With five regional sites, we offer residential treatment, foster family care, and family preservation services.

In 2001, we became one of seven national demonstration sites funded by SAMHSA to develop model training approaches designed to reduce the use of restraint and seclusion in residential services for youth.

Our population of youth ranges from 6 to 18 years of age, with a range of IQs between 70 and 120. For most of our clients, we are not the first placement out of the home; almost all have experienced multiple foster and residential placements before coming to our agency.

All come with psychiatric diagnoses, the most prevalent being oppositional defiance, conduct disorder, reactive attachment, bipolar disorder, post-traumatic stress disorder and depression. The use of physical restraint and seclusion has, unfortunately, been a necessary part of our behavior management interventions designed to keep youth and staff safe in moments of crisis.

## Lessons Learned During the Grant

Most training vendors are just that—vendors. When we initiated activities under the auspices of the SAMHSA grant in October 2001, one of our first tasks was to review as many of the major U.S. training programs in crisis intervention as feasible, given time and fiscal restraints.

We reviewed several vendors, including the crisis intervention program the agency had been using for the past 10 years. This review and subsequent experiences during the life of the grant led us to

realize that trainers in the area of restraint claim an expertise and display an arrogance about their programs that prevent any meaningful dialogue about the inherent risks in their methods. All claim to be safe, effective, able to be used by all staff, on all types of clients, with little or no risk of injury to the parties.

This “guru” mentality among most of the major training programs we have encountered makes it even more difficult to work with challenging youth with an objective, critical examination of risks involved with certain restraint techniques and programs. Similarly, national accrediting or credentialing bodies seem to have little or no motivation to advance this type of dialogue and scrutiny concerning restraint programs.

*Because workers in our field are entrusted with the care and protection of children, there is often an organizational need to blame someone when children are harmed in our care*

Training, in and of itself, has little effect on practice. Most youth-care agencies bring in outside training programs as a quick fix to the problem of crisis management of aggressive behavior, thinking, “Let’s train all of our direct care staff, and move on to the next problem.” The reality of skill erosion, however, particularly in the area of physical restraint techniques, points to the need for regular practice by staff immediately

following the implementation of a training program.

Moreover, many agencies see the acquisition and maintenance of knowledge and skills by staff as the responsibility of the agency’s trainer or training department, not as a responsibility of administration and leadership. This leads to a separation of training from organizational goals and everyday operations.

Crisis management training is not a quick fix for deeper, more complex organizational problems, but it is all too often a knee-jerk response to many agency issues that emerge when delivering services to a challenging population. When problems persist, leadership’s innate response is to blame training, or the participants who “just didn’t get it.”

Experience has taught us that sometimes what gets reinforced, in subtle ways, is a culture of blame, wherein we look to assign fault if something goes wrong after staff have been trained. One sees this most dramatically following a physical restraint gone wrong, even when staff have been trained. Even the trainers will turn against those staff following such incidents, declaring, “He or she should have known better—it’s not what we taught in the training.” This phenomenon, known in the literature as attributional bias, led to our next lesson...

Organizationally, moving away from a “blame culture” is no easy task. Because workers in our field are entrusted with the care and protection of children, there is often an organizational need to blame someone when children are harmed in our care. Following incidents of restraint, during staff debriefing, usually by supervisors, someone invariably asks, “What could you have done differently?”

The answer, of course, is that one could have always done something differently. Hindsight is 20/20. We have focused so exclusively on protecting children that we have ignored the fact that staff, when intervening to protect, often become targets of occupational violence, no less so than police and other high-risk professionals.

***The move away from a blame culture must start at the top, with leadership, and filter all the way down to frontline supervisors.***

The move away from a blame culture must start at the top, with leadership, and filter all the way down to frontline supervisors. Immediately following episodes of crisis and challenging behavior, practitioners need support, not scrutiny and interrogation designed to discover what was done wrong. Asking staff, “What do you need right now?” immediately after a restraint sends a very different message than asking, “What could you have done differently?” Making the change from a blame culture to a supportive culture does not come about easily, but in the end, it’s worth it.

It’s vital to look at an incident of restraint contextually, rather than focusing solely on the participants involved. So many factors involved in a crisis event go beyond the incident between a particular child and staff person. Problems in school earlier in the day, a peer conflict on the playground, mom not calling when she promised, or seeing someone else’s parent pick a roommate for the weekend home visit are but a few examples of the underlying events that might lead up to that one event that triggers challenging behavior.

We have found that focusing on the context within which a restraint occurs, rather than on what the child and staff did leading up to the restraint is more helpful and more meaningful.

## **Changes Implemented as a Result of the Grant**

Although quantifying philosophical and attitudinal changes resulting from our experience during the SAMHSA grant is difficult, the following list summarizes the concrete, visible changes we have undergone:

- Hiring practices have changed significantly to ensure staff can actually perform a physical restraint if necessary. Preemployment screening is more rigorous than ever before.
- Universally, our clinicians conduct structured preadmissions risk assessments when a child is admitted to the agency, and share this information at staff meetings before the child enters placement.
- The cottage team completes a functional analysis of behavior for each child during the initial placement period, focusing on challenging behavior that is part of the script the child arrives with.
- Staff and child debriefing protocols reflect the fact that both parties need agency attention and support following a crisis.
- Monthly practice of all restraint techniques, by both our staff and trainers, is a critical component of skill retention.
- Our trainers are our supervisors, working in the programs on a daily basis. As such, they are our occupational experts in the workplace.
- Building our training infrastructure by having trainers in every cottage expands ownership of the techniques and philosophy of our crisis-management program.
- Staff believe in the safety, effectiveness, and “social validity” of our restraint techniques. Likewise, when children lose control, they claim they don’t feel “jumped on” or manhandled by staff.
- Independent verification of training competence in our restraint techniques give staff confidence that they truly are being judged as competent at the end of training. In our new system, the trainer who con-

ducts the crisis management training is not allowed to test his or her participants at the end of the training session—testing is left to another individual.

- Annual reaccreditation of all staff and trainers is vital to ongoing quality assurance efforts.
- Eliminating the use of seclusion and the use of *pro re nata* medications has had no effect on the frequency of restraint throughout the agency. In other words, we’ve learned these two interventions are not necessary in managing challenging behavior in our youth.
- By reporting injuries to our training provider, we ensure continual dialogue and feedback on the techniques and special situations encountered during a restraint.

***Asking, “What do you need right now?” immediately after a restraint sends a very different message than asking, “What could you have done differently?”***

In our experience as one of the demonstration sites during the three-year SAMHSA federal grant, we have learned a lot about both ourselves and the issue of restraint and seclusion of young people. As Einstein once remarked, “The mind expanded can never go back to its original form.” We, as an agency, can never go back to the way things used to be before we became involved in the grant.

*Michael J. Budlong, ACSW, is Clinical Director, Methodist Home for Children and Youth, Macon, Georgia.*

# Courageous Patience Part II: Lessons Learned from a Five-Year Program to Reduce/Eliminate Restraint and Seclusion

By Robert Plant

*Good ideas don't just happen. They must be driven into practice with courageous patience.*

—Admiral Hyman Rickover

Since 1999, Connecticut's Riverview Hospital has been actively engaged in a multifaceted program to reduce the use of restraint and seclusion.

Riverview is the only state-operated psychiatric hospital for children and youth in Connecticut. The hospital operates under the authority of the State Department of Children and Families.

Riverview is authorized for 107 beds and serves approximately 280 children and youth annually, ages 5–17, including those with serious and often persistent psychiatric disorders who are referred from hospital emergency rooms, other privately operated psychiatric hospital units, residential treatment programs, juvenile justice facilities, and the juvenile courts. Some 420 multidisciplinary and support staff provide care in this hospital, accredited by the Joint Commission on the Accreditation of Healthcare Organizations and affiliated with Yale University.

Over the past five years, the hospital has used a range of strategies and interventions to reduce restraint and seclusion. The approaches can be grouped into the following seven broad but often overlapping categories:

- Organizational Culture
- Program Philosophy and Milieu
- Quality Assurance
- Policy and Procedure
- Staff Development and Training
- Leadership
- Cultural Diversity

Experience has taught us that a persistent multipronged effort is necessary to achieve and sustain reductions. The top three interventions to date have been a redesign of the program philosophy and milieu, staff training initiatives, and leadership.

## Program Philosophy and Milieu Redesign

The program redesign has been described previously in some detail (Plant, 2003; Donovan, Siegel, Zera, Plant, & Martin, 2003). Key concepts involved building better relationships between staff and the children and youth served and reducing power struggles and the use of coercion that contributed to assaults and the need for restraint and seclusion.

The program was designed to bring a consistent approach to the eight hospital units and to counter concerns about increased use of consequences and restrictions following negative behavior, reduced opportunities for positive interaction between staff and patients, overuse of time-out and room time for transitions, and a lower threshold for using restraint and seclusion.

The ABCD program was named after the four key values at the heart of the redesign: Autonomy, Belonging, Competence, and Doing for Others. The purpose was to create an environment that supported expression of autonomy or the ability to make choices and have an active meaningful role in one's own life, promoted belonging or positive relating, increased self-esteem and a sense of competence or mastery, and supported doing for others in the context of community.

The program has shifted from a points-oriented and consequence focus to a relationship basis in which direct-care staff's role as coach is key. Positive verbal feedback and small immediate bonus points for prosocial behavior replaced point loss and level drops as the primary interventions.

The program also shifted from teaching by consequence to seeing crises as opportunities to develop self-knowledge and coping skills. We placed further emphasis on ensuring expectations for behavior are developmentally appropriate and that core values are articulate clearly.

After the initial training, we developed a program committee, program consultants, and a fidelity measure to prevent program drift and maintain the integrity of the program.

## Staff Training Initiatives

Throughout the project, management created a number of staff training initiatives. One focused on increasing the verbal deescalation component of the behavioral intervention program. Another was a comprehensive training curriculum to support the skills necessary to implement ABCD.

The hospital's behavioral intervention program (Therapeutic Assessment, Communication, and Education, or TACE) was developed in house in conjunction with two other state operated residential treatment programs. Since the hospital owns the program, the training group is free to update, modify, and improve the program as knowledge and needs change. Over the years, modifications have included improved debriefing, expanded verbal deescalation,

and more time devoted to clarifying the concept of imminent risk.

The second and most comprehensive training initiative was to establish nine 45-minute training blocks per week for direct-care staff on diverse topics, from working with culturally diverse populations to reducing coercion, promoting impulse control, and understanding how trauma affects brain development.

The repeated, short format was selected based on adult learning theory, with the aim of maximizing attendance without adversely affecting staffing needs. The format also reinforced the concept of a learning culture where training is continuous and staff are constantly engaged to improve their practice. Key components included staff input into the training topics and involvement in creating and delivering presentations.

## Leadership

Riverview's leadership change strategies focused on a consistent, persistent, continued emphasis on reducing restraints and seclusions in the face of significant staff resistance—the courageous patience factor. The work is never done in this area, and constant effort and planning are required.

Concrete goals were set for each unit, and systemic changes in the supervisory structure were created to support the goal. Efforts have been made to integrate staff development, program philosophy, policy and procedure, supervisory structure and other hospital systems to support the reduction of restraint and seclusion.

## Results

The bottom line is the rate of mechanical restraints and seclusions declined significantly at Riverview Hospital (a 64% decline in mechanical restraints, a 47% decline in seclusions, and a 17% decline in physical restraints). Due to our initial emphasis on the most intrusive interventions (mechanical restraint and seclusion),

the rate of physical restraints declined only slightly.

Meanwhile, the restraint-related injury rate to children has remained constant, while the injury rate for staff has gone up. Based on the data and experience of our colleagues at the Department of Mental Health in Massachusetts, we expect injury rates will decline significantly once the successes we have achieved with mechanical restraints and seclusions are replicated with physical restraints.

## Challenges

The most significant challenges have been dealing with staff resistance, reducing injuries, and staying focused while dealing with other competing demands and priorities.

Staff resistance has ebbed and flowed throughout the project. Most staff members see the value in reducing restraints and seclusions and have fully embraced the project, but resistance remains, fueled by safety concerns in light of staff injury.

Some staff do not yet trust that the environment will be safer once we have dramatically reduced the frequency of all forms of restraint and seclusion. Caring for children and youth with severe behavioral and psychiatric problems is intense work—both intensely rewarding and intensely challenging and stressful.

Many competing priorities and demands exist. Perhaps the most challenging conflict is the need for staff to have enough time for quality interactions with children while also spending time on their own to develop programs, reflect on their work, and receive training and supervision. Balancing these needs in light of budgetary and regulatory realities is difficult but doable.

## What Might Have Been Done Differently

Our primary intervention, implementation of the ABCD program, has been a major challenge. Although

dramatic positive changes have occurred, not all aspects of the program have been effectively implemented on all units.

In retrospect, the hospital should have devoted more resources earlier to ensure the program was applied consistently and that it retained its fidelity. This might have included assigning permanent consultants to each unit for program evaluation and support, and establishing a stronger linkage between individual and unit supervision and program performance.

Although focusing initial efforts on mechanical restraint and seclusion made strategic sense, we might have had better outcomes if we had placed equal emphasis on reducing physical restraints at the outset. The stepwise approach made the initial goals more attainable but might have made the job harder in the long run.

Finally, we were several years into the project before we recognized the importance of supervision to reinforce training, the new program, and the restraint and reduction initiative. Good supervision is critical, and our supervisory structure has since been improved to support our goals.

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# Best Practices in Behavior Support: Preventing and Reducing the Use of Restraint and Seclusion

By Christopher O'Brien

In July 2001, Girls and Boys Town (GBT) partnered with the A.B. and Jessie Polinsky Children's Center (PCC) in a systematic, collaborative effort to implement the GBT System of Care within PCC. In September 2001, this partnership received a three-year SAMHSA grant to demonstrate the effects of GBT's training and technical assistance on the use of restraint and seclusion.

PCC is a 24-hour emergency shelter in San Diego for children who must be separated from their families for their own safety, and for children whose parents either have neglected, abused, or abandoned them or cannot provide care due to incarceration.

The 10-acre campus includes six residential cottages (although the program intervention occurred in only five), an infant nursery, medical clinic, school, library, cafeteria, gymnasium, swimming pool, baseball field, and two playgrounds.

Since 2003, an average of 210 children a month, birth to age 18, have come to PCC—approximately 2,500 children a year. The average daily population is 105 children; the average length of stay, 17 days.

Over the course of the grant, PCC reduced the use of seclusions by 99% (see Figure 1). Despite this significant decrease, the use of more-restrictive interventions did not increase during the first two years of the project. In fact, physical restraints decreased 23% by the end of the second year (see Figure 2).

Similarly, according to climate surveys, both staff and youth perceived improvements in youth safety. For example, when staff were asked in November 2000 whether they agreed with the statement, "This facility is a safe place for youth," only 41% agreed. By May 2004, however, 79% of staff agreed with the statement, and by the end of the project, 93% agreed.

Youth ratings rose by 23% when they were asked whether they agreed with the statement, "I feel safe at this facility." Only 65% of youth agreed in November 2000; 80% agreed in May 2004.

## Interventions

A combination of key interventions were responsible for PCC's success in reducing restraint and seclusion.

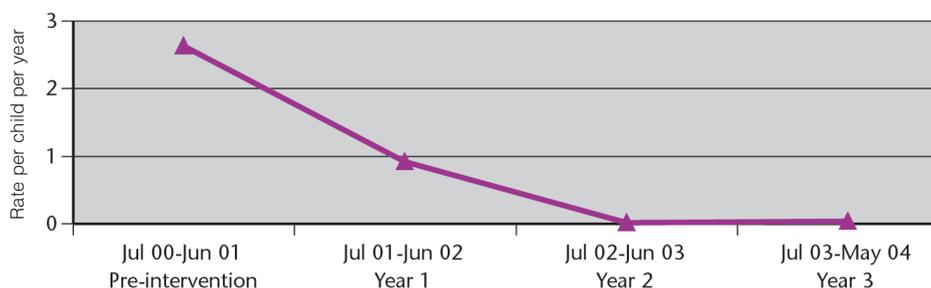
First, all staff, including a number of nonagency temporary staff during the first two years, received skills-oriented, criteria-based training in the GBT Psychoeducational Treatment Model, including

- teaching youth behavioral and cognitive techniques for recognizing antecedents and triggers and

for deescalating their behavior before or during crises;

- skills for reinforcing youth for successful attempts at preventing crisis episodes, and teaching youth appropriate replacement behaviors when crises occur;
- effective deescalation strategies, such as praising approximations, use of empathy, staff silence, offering youth "space," or using humor to help staff stay out of power struggles and remain emotionally neutral in crisis situations;
- a nonpunitive motivation system that holds youth accountable for their behaviors and enhances skill acquisition;
- encouraging effective staff-to-youth relationship-building tools, such as participating together in activities, meals, and discussion; sharing ideas; and trading opinions that build a warm, nurturing environment; and
- skill practice exercises for monitoring and enhancing appropriate staff-to-youth communication in areas such as body language, voice tone, facial expressions, and

Figure 1: Polinsky Seclusion Incidents



proximity, and for assessing performance on all proactive strategies learned in class.

Second, PCC established a quality assurance and staff management system, including

- reassigning and creating new supervisory positions that provide constant staff oversight in all cottages;
- identifying critical success factors related to reducing restrictive techniques, and data-collection procedures that measure youth, staff, and program performance;
- implementing skill-oriented, criteria-based training and on-the-job coaching of specific data-collection measures for all supervisors;
- implementing quarterly programmatic responses based on outcome trends; and
- training on incident reporting, including definition review, reporting guidelines, and documentation procedures to promote a consistent, reliable measurement of incidents.

Finally, PCC transformed several milieu conditions through administrative mandate, including

- developing a successful diversion program for sending change of placement (COP) youth to alternate and appropriate placements to control for overpopulation;
- promoting a family-style environment by allowing youth to keep

appropriate personal belongings, put appropriate pictures on the wall, and wear appropriate personal attire, and by making structural and cosmetic improvements in all cottages to diminish the institutional appearance;

- revising emergency response policies and procedures that ensure nonobtrusive staff notification, limit the number of staff responding, and include a staff debriefing process;
- creating cottage schedules, and including structured therapeutic and nontherapeutic activities;
- increasing consistent permanent staff in each cottage by limiting use of nonagency temporary staff and hiring a pool of on-call staff; and
- enhancing monitoring by reducing the youth-to-staff ratio and rearranging schedules to limit the amount of time youth congregate.

### Outcomes

PCC saw an overall decrease in restraint incidents during the project’s first two years; during the third year, however, there was a marked increase in the restraint rate. This is attributable primarily to the situation in one particular cottage and, to a lesser extent, the situation in two other cottages.

The cottage with the only significant increase in restraint incidents was Cottage F (junior-aged girls). Figure 2

shows the increase in physical restraint incidents by cottage. In the third year, two factors in Cottage F limited implementation of the program model as trained.

First was a lack of consistent supervisory leadership and staff development. During this period, Cottage F had three different program supervisors, two of whom were new to PCC. Moreover, six different cottage shift supervisors were employed during this time. The high turnover and limited experience in shelter settings resulted in a decrease in support and development of direct-care staff.

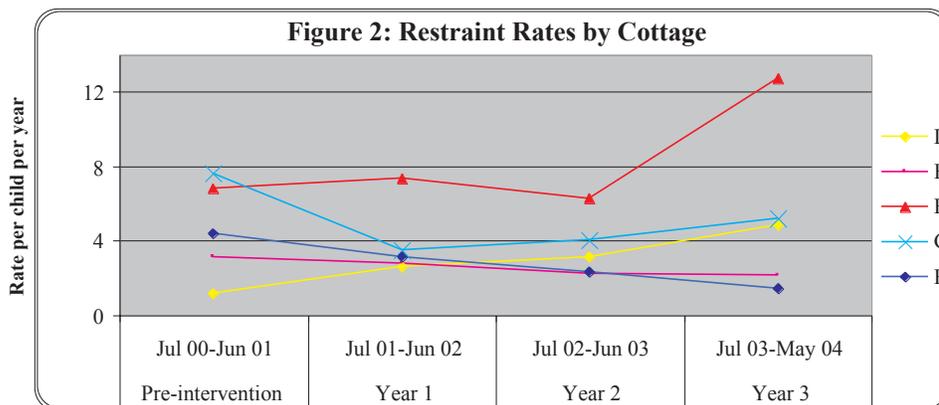
Cottage F’s direct-care staff experienced a 79% reduction in documented observations during this period. Observations are designed to enhance staff skills regarding model implementation.

Interestingly, training data revealed that Cottage F staff, on average, had the highest ratings on written and skill practice assessments, suggesting that training alone—independent of ongoing, consistent staff support and development—is a fairly weak intervention.

Second, was a disproportionate percentage of change of placement (COP) youth (youth who are already adjudicated and are being returned from an unsuccessful placement). Approximately 41% of the total child population in the other four cottages were COP children, whereas 65% of Cottage F’s population were COP children. This higher percentage of COP youth may have contributed to the increase in restraints in Cottage F.

Figure 3 displays how the average restraint incident rate decreases when the intervention is implemented as trained cottages house manageable levels of COP youth, and staff members receive consistent supervisory support.

Unlike Cottage F, Cottage D (children ages 6–10) and Cottage G (boys ages 10–12) had fairly consistent



leadership and staff management. The contributing factor in the slight increase in restraints, therefore, was not staff development or disproportionate percentage of COP youth. In Cottages D and G, the average number of restraints was inflated by a small number of youth who were frequently restrained.

For example, 97% of the Cottage D population and 91% of the Cottage G population experienced zero restraints during the 2003–2004 time frame. In Cottage D, only four youth accounted for 72% of all restraints. Similarly, only five youth in Cottage G accounted for 70% of all restraints during year three.

## Challenges

One of the main challenges encountered early in the project was the ambiguity associated with measuring and coding physical restraints and seclusions. This was due, in part, to the lack of clear definitions of restraint and seclusion, and inconsistent documentation or a lack of documentation of their use.

In April 2001, staff received explicit definitions of restraints and seclusions and detailed information about measurement protocols. Data collected before April 2001, however, are unreliable and grossly underreported, making it difficult to measure the full impact of interventions.

Another challenge was the fact that the placement needs and treatment issues of some children brought to PCC are beyond the scope of ordinary emergency shelter care services. Most of the children with higher-level placement and treatment needs are COP youth. Nearly half of all COP youth admitted are from psychiatric hospitals or juvenile detention, or are AWOL.

These children have many challenging behaviors and problems—sexual reactive behavior, acute or chronic psychiatric disturbances, substance abuse, and serious developmental delays. PCC's effort to decrease these difficult-to-handle children has been limited at

times by the lack of available and viable alternative community placement resources.

Despite being poorly equipped to care for COP youth, PCC has enjoyed some success with them. For example, 82% of the COP population experienced zero restraints during the 2003–2004 year. But the remaining 18% of the COP population was responsible for 94% of all restraint incidents. To address the challenge, GBT has plans to provide all cottage staff with functional assessment and individualized treatment planning training.

An additional challenge is the fact that, at times, PCC depends on temporary residential care staffing when permanent staff members are ill or on leave, or when the youth population increases and PCC cannot meet staff ratios with permanent staff.

To increase their usefulness and match the skill level of permanent staff, PCC provided training for some 100 temporary staff members. At the beginning of the 2003–2004 year, however, a more fiscally sound contract was negotiated with alternate staffing agencies, resulting in new pools of temporary staff. Concurrently, budget constraints allowed for only 20 of the staffing pool to be trained.

The final noteworthy challenge is the periodic pressure placed on PCC by stakeholders to reduce runaway incidents by using more-restrictive or controlling interventions. For example, PCC has installed protective separation rooms in each cottage. Since July 2004, the rooms have been used to contain or seclude youth who attempt to go AWOL or pose other serious safety issues. To safeguard against overuse, new policies and procedures require administrative approval before the rooms' use.

## Different Approach

Since the beginning of the project, PCC has virtually eliminated seclusion inci-

dents across cottages and reduced restraint incidents in four of the five cottages. As noted, however, the baseline data make it difficult to measure the true effect of the interventions. Incident definitions and measurement protocols should have been more firmly established and more fully introduced in the training before intervention.

A review of similar studies revealed that in applied settings, investigators often struggle to adequately control for mediating variables and other external challenges. Although randomized clinical trials of restraint and seclusion reduction programs may not be ethically possible, before-and-after designs could be strengthened by using control or comparison groups with demographic characteristics and diagnoses similar to the experimental group, incorporating repeated measures of outcomes, or statistically controlling for potentially mediating variables. These measures would have strengthened the study design and increased the validity of our findings.

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# Q: *Should all organizations that provide training for behavior support and crisis management be required to use a certified model?*

**POINT:** Many training vendors and residential agencies provide behavior support and crisis intervention training, but none of these training programs have been certified or accredited to ensure they are comprehensive, effective, or safe. All training programs should be required to be certified, regardless of whether the training is provided by a training vendor or residential agency. The use of unlicensed training programs may further jeopardize the safety of children and staff during crisis situations.

*By Michael Nunno*

The behavior support system your treatment facility employs during moments of interpersonal crisis will govern staff-child interactions when your children are at their most angry, frustrated, confused, and frightened. The tone set and the lessons learned from the resolution of these events—on both interpersonal and organizational levels—reflects the culture of safety, treatment, and learning in your facilities.

Environmental and verbal strategies help engage agitated and aggressive children as they learn self-control. Environmental and verbal strategies are not inherently risky, except when used poorly and out of context. Physical interventions that move or contain children against their will are inherently risky, and have been linked to serious physical and emotional injury. Such physical interventions should be used to ensure safety only when other less risky methods are not immediately available.

*see POINT, page 18*

## COUNTERPOINT:

Every day, more and more agencies are learning that behavior support and crisis management training itself is not the answer to reducing restraint and seclusion. Fortunately, agencies have become much more creative in their approaches to reduce these restrictive procedures. But by certifying these training models, we may create an atmosphere that views training as an end-all. Certification may place more attention on the certification process and trainings and less on what agencies are doing internally to reduce their use of restraint and seclusion.

*By Bob Bowen*

The Children’s Health Act requires regulations that “support the development of national guidelines and standards on the quality, quantity, orientation, and training, required under this part, as well as the certification or licensure of those staff responsible for the implementation of behavioral intervention concepts and techniques.” [P.L. 106-310, Part I, Sec. 595B (a)(3)].

No national guidelines and standards address the “prevention and use of restraint” [P.L. 106-310, Part I, Sec 595 (b) (1) (B)] or the quality, quantity, orientation, and training required to prevent the use of restraint, or the requirements for certification or licensure of those staff. As a result, conflicting definitions exist within the federal government, among the states, and even within states. This confusion makes it practically impossible to collect data in an evidence-based practices format and makes it difficult to assess the validity of claims by vendors who boast of their abilities in training the prevention and use of restraint.

*see COUNTERPOINT, page 19*

All restraints assume some sort of risk. When restraints are employed, they require interpersonal and organizational self-assessment, review, and monitoring, or they risk being abusive and ill-suited to treatment. The only safe restraint is one that doesn't happen.

Selecting a behavior support and a crisis prevention and management system is difficult and time-consuming. A few guidelines can ensure that a system and its techniques are appropriate to your organization's mission, treatment program's philosophy and values, and population served. You'll also need to consider federal and state regulatory requirements, level of staff education, staff training, and staff capabilities.

Facilities would therefore benefit from a robust certification system to aid in the selection process and to protect the consumer. Certification would require that vendors meet minimum standards necessary to ensure safe delivery of any training and technical assistance. These standards would generally include structures and processes necessary for performance monitoring, goal attainment, professional conduct, and recordkeeping. Certification would help ensure that vendors offer comprehensive, effective training and technical assistance programs supported by theory and research.

Our British colleagues, who have been certifying behavior support training programs since 2001 (British Institute for Learning Disorders, 2001), articulate immediate benefits such as greater consistency among trainers, higher training standards, closer collaboration, more effective monitoring, fewer injuries, and a reduction of physical intervention in practice. They also view certification as a vehicle that supports research to build a vigorous body of evidence-based practice.

But selecting a certified crisis prevention and management system is only half the task. The other half is more difficult. A certifying body would also have to assess the philosophy, origins, strategies, and techniques in any crisis

prevention system to ensure it's consistent with the agency's mission, values, and guiding principles. The current multiple systems used in the United States and United Kingdom have unique histories and evolutions. But some are not appropriate for child populations or are inconsistent with treatment philosophies. Crisis-prevention systems, even those designed for children, are not foolproof.

Not every strategy or intervention works well with every child, and some strategies or interventions are potentially dangerous with certain children. Take interest in vendors who ask about your child population and the children's developmental needs first (and look for the same interests in your staff). The same is true for your staff—look for vendors who are cognizant of your staff abilities and condition and who can tailor their training to meet your staff's unique training needs.

Certified or not, every crisis prevention and management system requires frequent systematic reviews by physicians, physical therapists or biomechanical engineers, psychologists, and learning specialists. This will maximize the potential for a safe, developmentally appropriate outcome, especially regarding physical interventions.

Gravitate toward systems that are clear about the potential safety hazards and misuses of their techniques and that offer clear contraindications and safeguards to their use, especially

with emotionally and medically vulnerable children. Just as you wouldn't change a medication dosage without consulting a physician, never change or modify any technique or strategy without consulting with your crisis prevention and management vendor.

Seek vendors who are active in the professional dialog over evidence-based practice, and those who publish in peer-reviewed journals. A certified crisis prevention and management system that employs extensive ongoing study, review, and testing of its strategies and techniques is a learning organization. Be prepared for modifications, changes, or terminations of certain techniques based on field monitoring, testing, and other evidence from the medical, legal, and psychological research literature.

Choosing from crisis prevention and management systems that meet certification standards can help ensure your facility's overall safety and that the child's developmental learning are paramount.

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#### *In the next Residential Group Care Quarterly Point/Counterpoint...*

**Question:** *Are point and level systems effective tools in improving the outcomes of children and youth in residential treatment?*

**Point:** *By tangibly rewarding positive behavior and discouraging negative behavior, point and level systems are successful tools in bringing about lasting behavioral change. Point and level systems should continue to be utilized in residential treatment facilities.*

**Counterpoint:** *Point and level systems inhibit the formation of strong relationships between children and staff, and keep children from learning internal behavior controls. Use of point and level systems should be discontinued in residential treatment facilities.*

More serious is the fact that without national guidelines and standards, people served in various service sectors will continue to be at risk. One would like to think that since the publication of the “Deadly Restraint” series in *The Hartford Courant*, fewer people would be injured or die due to restraint. But the deaths continue, the injuries mount, and organizations providing training continue to make claims arguing that if their programs were used the outcomes would have been different. Absent national guidelines and standards, such statements are meaningless unless they are supported by research and data.

Providers of services and supports need additional tools to determine if trainers in the prevention and use of restraint meet minimum standards developed within a framework of national standards. When I was directing residential programs, I questioned the need for accreditation through the Commission on Accreditation of Rehabilitation Facilities (CARF) or the Council on Accreditation (COA). But after going through the accreditation process, I realized two things: The quality of our services really did improve, and the people who select the approved service organization valued the information presented in the accreditation report, as it provided them with a set of standards they could use to compare one provider with another. Results of accreditation surveys are available to the public in a number of states, and at least one state, Ohio, has an active process to teach consumers how to make comparisons on the basis of standards between providers of residential and vocational services (see [www.myvoicemychoice.com](http://www.myvoicemychoice.com)).

Using a nationally recognized accrediting body such as CARF, COA, or the Joint Commission on the Accreditation of Healthcare Organizations would provide a measure of assurance to the people and organizations in the market for training that the guidelines and standards have some measure

of validity. Some have suggested that vendors themselves set the guidelines and standards, as we are “the experts.” Although I believe we should be part of the process, I take the claims of self-regulated industries and services with more than a few grains of salt.

The process of creating national guidelines and standards will be difficult, but not impossible. In fact, we can build on much of the work that has already been done. For instance:

- The British Institute of Learning Disabilities has developed non-physical standards. (see [www.bild.org.uk/physical\\_interventions/index.htm](http://www.bild.org.uk/physical_interventions/index.htm)).
- The ArcLink has a best-practices statement on the use of positive behavior support, which also addresses the use of restraint and other aversive interventions (see [www.thearcink.org/news/article.asp?ID=537](http://www.thearcink.org/news/article.asp?ID=537)).
- CWLA has developed a list of prohibited practices as applied to physical interventions. *The Best Practices Guidelines for the Use of Behavior Support and Behavior Intervention* provides an excellent base upon which to build (see [www.cwla.org/programs/behavior/pubs.htm](http://www.cwla.org/programs/behavior/pubs.htm)).
- The International Association for Continuing Education and Training (IACET) has an accreditation process that reviews not what is taught but rather how teaching takes place. IACET’s standards also ensure that development of a curriculum, evaluation of that curriculum, and presentation of the curriculum to adults follow a set of standards the organization has developed (see [www.iacet.org](http://www.iacet.org)).
- Design Research Engineering, a bio-mechanical and biomedical consulting firm, has evaluated one provider of training in “the prevention and use of restraint” and has developed a body of evidence that can be used in the process of developing standards. The organization is will-

ing and eager to assess other providers as well and develop a comparative data base between all physical techniques (contact [ChrisV@dreng.com](mailto:ChrisV@dreng.com)).

If we do not start setting national guidelines and standards on quality, quantity, orientation, and training, then someone else will. It took the deaths of at least 142 people to move people from simply training on the use of restraint to focusing instead on the prevention of restraint and then, if necessary for safety, the use of restraint. At some point, someone will be injured or someone will die, and then national guidelines and standards will be set in a rush to judgment.

Let’s practice what we preach. Let’s be proactive and not reactive in addressing the need for national guidelines and standards.

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