A Multi-Faceted Approach to Restraint Prevention

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Justice Resource Institute works in partnership with individuals, families, communities, and government to pursue the social justice inherent in opening doors to opportunity and independence.
Who is JRI?

- Est. 1973
- Programs in CT (Susan Wayne Center of Excellence, CBS, Foster Care), MA, RI, PA, with individuals from across the nation
- Continuum of Services:
  - Residential treatment
  - Group Homes
  - Pre-Independent Living
  - Psychiatric/locked facilities
  - Juvenile Detention
  - Community-based services
  - Foster Care
  - Outpatient Clinics
  - And more!
- Serving the entire life span
- Committed to Clinically Sophisticated Programs Linked to Our Mission
Trauma Informed Model

- ARC – Attachment, Self Regulation, and Competency
- Framework for Intervention with Complexly Traumatized Youth (Kinniburgh and Blaustein, 2005)
Trauma Informed Model

- Model that is pervasive throughout all aspects of programming
- Model focuses on attachment, regulation, and competency building as part of all aspects of students’ lives
Who does ARC target?

- Designed to target the needs of children, families, and systems impacted by complex trauma
- Core domains translate across children/families/systems; applications and goals will vary
- Crucial importance of:
  - Keep an eye on the target, rather than the technique
  - Pay attention to relative goals and relative successes
  - Have a plan, but catch the moments

Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005
ARC Treatment Outcomes to Date

- PTSD Symptom Reduction (Outpatient, Residential)
- Child Behavior Improvement (CBCL)
  - Outpatient (85% percentile to 50% percentile)
  - Residential (sig reduction Externalizing Problems; positive trend Internalizing)
- Significant Restraint Reduction
- Significant increase in Placement Permanency (92% vs. under 50%)
- Increased staff knowledge, skills, attitudes, job satisfaction, job permanency/advancement

Blaustein & Kinniburgh, 2010; Kinniburgh & Blaustein, 2005
Case example - “Katie”

- 16 year old adopted, African American female.
- Treatment at VDK for 8 months.
- Incoming Diagnoses: Reactive Attachment Disorder, Bipolar, PTSD, ADHD, ODD, R/O Borderline IQ.
- Presentation at intake:
  - High levels of dysregulation and reactivity.
  - Regressive, “primitive” and self-harm behaviors when dysregulated.
  - Easily overwhelmed, leading to becoming shut down.
  - Needed almost constant attention from adults.
  - Developmentally immature (i.e. childlike) interpersonal interactions.
  - Active PTSD symptoms.
  - Angered easily, often perceived hostile intent from others.
  - Negative self concept.
  - Limited ability to engage in school.
  - Difficulty making friends.
Two pronged approach targeting attachment and self-regulation across multiple levels of the environment (school, milieu, individual/group therapy) using ARC as a guiding framework:

Attachment:
- SMART: Build attachment with individual therapist through intervention that is not dependent primarily on verbal expression.
- Milieu interventions focused on building positive relationships (Ed and Res advocates) and getting needs for nurturance and affection met in a positive way (ex. hug plan).
- Training with all staff to develop conceptual understanding of Katie in order to increase attunement and empathic responding.
- Family therapy focused on building caregiver affect management and parenting skills centered on trauma informed limit setting, maintaining consistency, and supporting development of autonomy.

Self-Regulation:
- Neurofeedback (NFB): “Top down” regulation.
- Sensory Motor Arousal Regulation Therapy (SMART): Integration of sensory motor tools in the milieu and school contexts.
- Individualized planning in milieu to encourage translation of self-regulation skills (ex. settling plan) in day to day.
Katie - Restraint Data

The graph shows the number of restraints over the course of several months. The number of restraints decreases significantly from Month 1 to Month 5, after which it remains at a low level through Month 8.
Six Core Strategies

• Leadership Toward Organizational Change
• Use of (Sensory) Tools
• Use Of Data to Inform Practice
• Workforce Development
• Consumer Role in Inpatient Settings
• Debriefing Techniques
Six Core Strategies

- Leadership Toward Organizational Change
  - Task forces
  - Inter-program collaboration
  - Strategic Planning
Six Core Strategies

- **Use of (Sensory) Tools**
  - Client involvement
  - SMART rooms
  - Sensory prescriptions
  - Sensory classrooms

- **Other tools –**
  - Neurofeedback
  - Yoga
  - Theater
  - Competency
Six Core Strategies

- **Use of Data to Inform Practices**
  - Monthly data to include
    - Individual data
    - Data by date, time, shift, staff member
    - Trends – Proactivity
    - High-end users
  - Student data from debriefing meetings, forms
Six Core Strategies - Workforce Development – Link to our model

- Trainings on use of tools
- Investment in staff longevity
- ARC as Treatment Model
  - Organizational Commitment to ARC
- Now, the plan for Workforce Development….
  - Focus on connection of treatment model to our restraint reduction efforts
  - What practices/trainings were not in line with model…?
The Curriculum Development

- Taskforce
- Key Staff Involvement
- Client Involvement
- Key Stakeholder Involvement
- Pilot Program
- Overarching Oversight

Where are we now?
Curriculum Focus: Building Communities of Care

- Training on the Model
- Training on the Scope
- Training on the role of each staff
- Link to Restraint as Absolute Last Resort
The Concepts

- Environment
- Systems
- Treatment
- Engagement

Everyone must know their role to help create a community that focuses on the care of our clients.
Strategy 2: Six Core Strategies

- Consumer Role – previously stated – participate in focus groups, feedback forms, debriefing process, student council
- Debriefing –
  - PFA-based Debriefing
  - Staff involved, as well as admin/clinical
  - Sharing information
Our Journey

- Training Roll Out
- Commitment of our Leaders
- Link to Treatment Model
- Trainers
- Staff and Client Roles
- Review of Data
Training Data:

- 98% “pass” rate
- Approximately 75 trained-trainers
- In use at over 30 sites, including:
  - Res/ed
  - Day schools
  - Locked units
  - Foster family training
  - Group homes
  - After-school programs
  - DDS homes

Staff responses:
- Learned a lot about trauma-informed care
- Can better apply to actual clients
- Better understand the individual as part of a system
- Very comprehensive
MEADOWRIDGE SCHOOL DATA:

- Significant Improvement in 4/5 schools:
- From April 2012 to Jun 2014, Meadowridge Academy showed a nearly 30% decrease in restraint
- From Jul 2011 to Jun 2014, the Walden Street School showed a 62% decrease in restraint
- From Jul 2013 – July 2014, Pelham Academy showed a 65% decrease in restraint
- From July 2013 – July 2014, Glenhaven Academy showed a 35% decrease in restraint

Areas of Focus:

- Swansea Wood School saw fluctuations, but overall remained stable.
Restraint Reduction Data

- **Secure Programs**
  - Centerpoint – From July 2013– Jun 2014, 57% decrease
  - Merrimack Center – From July 2013 – Jun 2014, 64% decrease
  - Cohannet Academy – From Jan 2013 – Jun 2014, 68% decrease

- **Connecticut Program Data**
  - Susan Wayne Center of Excellence – From July 2013 – Jun 2014, 20% decrease
  - CT Group Homes – From Mar 2012 – Mar 2014, 45% decrease

- Most sig. improvements have been the past year – why?
Training Barriers

- Training Model Length
- Entire Workforce to be trained
- Fidelity to model when spread to so many sites
- Supporting trainers across locations
- Replacing older curriculums that had been in use for years
- Connection to our stakeholders
More to come

- Restraint Data Reviews
- Staff Satisfaction
- Client Satisfaction
- Strong Communities of Care
For more information, please contact us!

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