RESIDENTIAL GROUP CARE QUARTERLY

VOLUME 3, NUMBER 3 CHILD WELFARE LEAGUE OF AMERICA WINTER 2003

Best Practices in Behavior Management

Preventing and Reducing Restraint and Seclusion

by Lloyd Bullard

The Child Welfare League of America (CWLA), in collaboration with the Federation of Families for Children's Mental Health, serves as the Coordinating Center for a three-year project designed to reduce the use of restraint and seclusion procedures with children receiving services in five demonstration sites across the country. In each of the sites, the project focuses on improving the training and supervision of staff who work directly with children and youth being served in residential and day treatment facilities. The project is funded by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) and also involves support from the National Association of Private Special Education Centers and the National Association of Psychiatric Treatment Centers for Children.

The Coordinating Center is responsible for three major tasks: providing technical assistance to the sites, evaluating the outcomes of the various interventions implemented at each site, and disseminating the results of the project to promote best practices in this critically important area. The project draws on input from field experts, as well as consumers and family members, to develop and demonstrate the effectiveness of a range of training models and programs in reducing the use of restraint and seclusion in facilities serving children and youth.

During Year 1, the Coordinating Center partnership will provide technical assistance to the five demonstration sites to support the development of their training programs. Technical assistance is based on CWLA's Best Practices Guidelines: Behavior Management, recent literature on the influence of organizational culture and the process of organizational change, and the need to involve children and family members in the overall change process. First-year activities also include design and implementation of the multisite evaluation system, which will measure the impact of training interventions on the use of restraint and seclusion.

During Year 2, the Coordinating Center's technical assistance will focus on helping the sites refine their training programs and better incorporate them into ongoing agency activities. This will involve training for supervisors and managers, training for trainers, and the development of organizational systems to ensure the training becomes completely integrated into the agency's culture. Additional Year 2 activities will include continued collection and analysis of evaluation data and identification of the most promising practices from the five sites.

Although the Coordinating Center will continue to provide technical assistance to the sites during Year 3, the focus will shift toward disseminating project outcomes. Center and site staff will document and publicize their results; develop written training curricula, practice guidelines, and other materials for the field; and convene a national conference to further advance development of a best-practices model of behavior management.

The project's overarching goal is to reduce agency reliance on restraint and seclusion by providing agencies with a model training and organizational development approach based on the work of the Coordinating Center and demonstration sites.

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The STAR Project

Staff Training and Resources to Support Best Practice to Prevent and Reduce Restraint and Seclusion

By Nancy R. Campbell

Brewer-Porch Children's Center is a mental health teaching clinic and social service agency within the University of Alabama, Tuscaloosa. The center's continuum of multidisciplinary services spans six programs that serve children and adolescents experiencing severe behavioral or emotional problems:

- Adolescent Adaptive Skills Training
- Community Autism Intervention
- Outpatient Day Treatment
- Residential Treatment
- Short-Term Treatment and Evaluation
- Therapeutic Foster Care

For the center's SAMHSA demonstration, the STAR Project, the use of restraint is being tracked across all six programs. Seclusion is being tracked across three campus-based programs, the only settings in which this intervention is permitted. Only manual restraint is employed; no mechanical restraints are permitted.

Historically, Brewer-Porch has been committed to the limited and safe use of containment and seclusion as emergency interventions. The center began paying closer attention to these interventions in the mid-1990s, however, following a period of rapid growth and subsequent reorganization. Increased attention to these interventions was also prompted by new certification standards issued by the Alabama Department of Human Resources (Alabama DHR, 1999) and in anticipation of new standards being developed by the Alabama Department of Mental Health and Mental Retardation (Alabama DMH/MR, 2002). These were related to a consent decree in the state and to changes occurring nationally in the wake of the well-known investigative series published in the *Hartford Courant* in 1998 (see page 10). Both DHR and DMH/MR standards consider restraint and seclusion to be emergency interventions, justifiable only to contain dangerous behavior when alternative interventions have not been successful or are not feasible.

By the time the SAMHSA grant was awarded, Brewer-Porch had amassed two years of relevant baseline data and was planning changes to its Orientation and Annual Training curricula, especially regarding the prevention and de-escalation of crises. The data revealed the center was successful in keeping most restraint and seclusions brief and safe for children involved. A major goal, however, was to further reduce the frequency of these interventions, especially in three programs that employ interventions most often.

STAR Project activities are directed toward three main sets of outcomes: (1) documentation of staff competency in deescalating crises and, when justifiable and necessary, appropriate use of containment and seclusion; (2) documentation that, when used, restraint and seclusion are employed safely for youngsters and staff and according to protocol; and (3)documentation of the reduction—and ideally, the elimination—of restraint and seclusion. Related goals include developing center infrastructure to support an expanded, more sophisticated database, and dis-

seminating related information throughout the state.

The STAR Project encompasses staff development and related organizational supports. Training has been consistently identified as an essential element contributing to staff's safe and appropriate use of restraint and seclusion in mental health settings. The literature also consistently indicates that success ultimately depends on broad organizational support throughout an agency (Busch & Shore, 2000).

During Year 1 of this three-year project, STAR has accomplished several key staff training activities:

- The center hired two staff trainers—the first staff committed full-time to staff training and development
- The center implemented a new model for crisis prevention and management: Satori Alternatives to Managing Aggression (SAMA) (Hampton, 2001). Five staff, trained as SAMA facilitators, trained approximately 165 employees in the model; orientation for new staff has been revised to incorporate this 12- to 15-hour class. During the initial three-month implementation, staff devoted 2,000 contact hours to SAMA training.
- The center trained 28 supervisors, ranging from shift leaders to senior administrators, in CWLA's Effective Supervisory Practice I (ESP I) course (CWLA, 2000), for a total of more than 500 contact hours in three days.
- The center is conducting a comprehensive review and updating orientation and annual training curricula and in-service plans.

SAMA was selected for many reasons—primarily because of its philosophical foundations, its prominent incorporation of a verbal deescalation "assisting process," and previous work demonstrating success in reducing injuries associated with the use of restraint.

The ESP I class was selected to provide intensive instruction in supervisory skills to a group of key center leaders—the program coordinators. The majority are young professionals relatively new to supervisory roles, who find themselves in demanding middle management positions without benefit of much prior instruction in supervisory skills. Other groups targeted strategically included staff who function in direct service as well as supervisory roles, such as shift leaders and classroom instructors, because of the role confusion they are apt to experience.

Key organizational support activities include

- involvement of stakeholders within and outside Brewer-Porch through its Advisory Committee, including community and family representatives, and internal committees;
- organizational self-assessment against *Best Practice Guidelines: Behavior Management* (CWLA, 2002) and via an organizational climate survey;
- updating of policy, procedures, clinical documentation, and programming related to effective treatment, behavior management, and crisis intervention;
- identification of promising practices through consultation with a broad range of experts, review of programs reporting success in reducing the use of restraint and seclusion with children and youth, and on-site visits by center staff to some of these programs;
- development of an expanded database of outcome and process measures, to be more useful clinically and for program evaluation and research; and
- development of an administrative and clinical weekly review of each instance of restraint and seclusion.

Although most initiatives are relatively recent, and staff have experienced some intermittent stress because of the pace of change, progress is evident. Of greatest significance, data indicate a decrease in the frequency of restraint and seclusion, especially in one program. Also of special interest, participant evaluations of training events have been overwhelmingly positive, and, overall, staff have been receptive and responsive.

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Restraint and Seclusion: The Lakeside Project

By Matthew S. Fox

Lakeside Treatment and Learning Center seeks to reduce the restraint and seclusion of the residents in its child and adolescent residential facility with an improved, comprehensive training program for residents, their families, and direct care staff. The focus includes a review of the literature, best-practice research, data collection, and analysis, as well as a training curriculum designed to improve both treatment and resident outcomes.

Most of Lakeside's residents have suffered emotional, physical, or psychological abuse. The children involved in the restraint or seclusion may experience flashbacks of previous abuse, thus impeding treatment and disrupting a trusting relationship with their caregivers. Some children may suffer further trauma by observing or overhearing a restraint or seclusion even when they are not involved in the incident. Staff who rely on the external control of children through the use of restraint or seclusion are less likely to teach residents self-control strategies and prepare them to return to the community. The use of restraint and seclusion, then, can prolong the length of stay for a child in residential care.

The children in Lakeside's care are not here by choice. The training model Lakeside has developed overcomes their lack of voluntary commitment by including them in important aspects of their care, including involvement in treatment planning, goal setting, program development and evaluation, client satisfaction, leadership, and peer training. Residents are trained in such self-management skills as anger management, self-esteem, and coping with issues of grief, loss, abuse, and neglect. Once residents have demonstrated skill in these areas, they have an opportunity to serve as peer mentors for other residents.

Lakeside's training model educates families and staff on the significance of historical issues, alternatives to physical management, and the safe use of physical management when necessary. Increased knowledge of the emotional, physical, and psychological risks associated with restraint and seclusion are addressed to prevent behavior management techniques from causing injury.

By learning about verbal deescalation and conflict resolution, parents should be able to maintain their children in a community setting upon discharge from the residential program.

Parents must play an active role in their children's treatment as well. After assessing the family's needs, Lakeside provides training in leadership, anger management, team building, and experiential learning. By learning about verbal deescalation and conflict resolution, parents should be able to maintain their children in a community setting upon discharge from the residential program.

In developing a training model for agency staff, Lakeside has created a comprehensive system to address mission, programs, core competencies, training, and assessment. The core competencies are intrinsically related to the qualities and skills a staff person must have to deliver services consistent with best practices. By identifying additional factors that contribute to the need for restraint and seclusion, Lakeside can develop interventions that should decrease the likelihood of their use.

The Lakeside Cultural Assessment Project is a major effort to assess how Lakeside's work culture may impact the restraint and seclusion project and the larger Lakeside vision. Lakeside has formed a cultural assessment team that includes a cross-section of Lakeside employees. An outside source leads and facilitates the team in developing a clear, shared, meaningful, and measurable articulation of the Lakeside vision for residents, customers, employees, and the organization.

Lakeside reduced the use of restraint and seclusion by 70% from 1996 to 2000, but that's not enough. We strive to demonstrate best practices and realize that with the anticipated changes in federal regulations concerning the use of restraint and seclusion, the safety and well-being of our residents is of primary concern. Ultimately, our residents, families, and staff will benefit from the restraint and seclusion grant to improve our training program. We look forward to sharing the model with other organizations and institutions.

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Closeup: The Devereux Glenholme School

by Mary Guilfoile

The Devereux Glenholme School provides therapeutic residential services to children and youth who display emotional and behavioral difficulty. These services are provided within a culture that focuses on positive values, moral education, and community service. Strength-based programming and family education help Devereux Glenholme youngsters achieve their goals and acquire the skills they need to function successfully in less restrictive settings.

As part of the Connecticut Collaboration for training excellence, Devereux Glenholme is participating in the Substance Abuse & Mental Health Services Administration (SAMHSA) grant project on reducing restraint and seclusion for children in care. Because of a strong commitment to staff training in the 1990s, Devereux Glenholme significantly reduced the use of restraint and time-out. Use of specialized treatment procedures (any physical control method including assists, escorts, controls, and restraints) and time-out declined significantly in the residential program and remain at low levels. In addition, the number of time-out rooms was reduced from five to one. These successes occurred despite increased severity of symptoms among the student population. Participation in the SAMHSA grant has allowed Devereux Glenholme to further reduce the use of restraint and seclusion through expanded training opportunities for direct care staff.

The Need for Training

Unlike clinical and educational faculty who are prepared for their roles during preservice education, direct care staff in residential settings have little relevant undergraduate experience and training, yet they have the largest influence on the lives of the seriously disordered children and youth in their care. As human services has moved to an "ecological" treatment approach, direct care staff have assumed a greater share of the responsibility for treatment. Direct care staff members must be able to create an environment that prevents disruption, teach new interpersonal and social skills, create relevant practice opportunities, ensure safety and security, and minimize the need for negative consequences. These are specific competencies not addressed adequately in undergraduate education programs. This project helps direct care staff acquire these skills through meaningful and motivational training options.

Project Description

The goals of the SAMHSA grant project are to

- maximize face-to-face classroom time,
- distribute courses to employees regardless of location,
- define training profiles for each employee,
- implement an evaluation, review, and update mechanism,
- effectively deliver training without increasing staff, and
- implement a tracking system for competencies.

The project addresses these goals through electronic learning options. An e-learning format meets the needs of a variety of learning styles, allowing for self-paced instruction, individualized instruction based on skill level, and ongoing tracking for professional development.

Two designers are creating customized computer-based learning programs that are consistent and convenient to use. Materials currently in use in training are being translated into engaging, self-paced learning modules that include assessment and score tracking. The topics include Effective Staff Behaviors, Analyzing Staff Behaviors, Guidelines for Therapeutic Interactions, Preventing Crisis Situations, Deescalation Techniques, Basic Counseling Skills, Safety Techniques, and Physical Control Techniques and Issues. Three modules and several videos are being pilot tested with new staff.

E-learning has the potential to reach more staff members quickly because classroom time can be reserved for hands-on practice and feedback. In-class time can be spent applying knowledge to work-related issues with greater emphasis on guided practice of skills and developing professional attitudes and responses.

E-learning also allows employees to access learning opportunities during program down time. This will be particularly beneficial to the groups working the second and third shifts. Training for these individuals currently means schedule adjustments or extra hours that interfere with employees balancing work and personal responsibilities. With the new system, employees will not be tied to a schedule to acquire basic knowledge.

Challenges and Plans

We are challenged to maintain the integrity of the training schedule, ensure enough trainers, and foster transference to daily operations. For the latter, supervisory observations and feedback are the most effective, ongoing reinforcement tool. Additional training on conducting observations and effective supervisory practices address these needs.

A second component of the training model includes 13 modules that address specific skills direct-care staff must implement effectively to create a supportive milieu. These topics will be addressed in the future: Understanding Behavior; Building Relationships; Listening to Understand; Praising Effectively; Making Requests that Work; Observing, Counting, and Recording Behavior; Verbal Warnings; Using Time-Out; Suicide Prevention; Ethical Decisionmaking; Teaching Values; Routines; and Transitions; and Conducting Engaging Activities.

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Safe Practice in Physical Restraint: A Transatlantic Perspective

by David Leadbetter and Michael Budlong

Historically, the use of physical restraint has been an accepted practice within human and child care services in both the United States and the United Kingdom. The frequency, effects, and safety of restraint practices, however, have been obscured by a range of ideological, political, and financial factors.

The legitimacy of restraint as a reactive crisis intervention tool to prevent injury and damage to property is relatively uncontroversial. Restraint has also been advocated, however, as a proactive intervention to promote a range of alleged therapeutic or developmental goals. Given increasing fatalities, the credibility and legality of many "therapeutic" approaches have received increasing criticism from groups such as Children Injured by Restraints and Aversives. The U.S. and U.K. governments have found the regulation of restraint practice a bitter political pill, however.

Consequently, a market economy of training provision persists, with considerable financial returns for the diverse range of training providers and users operating in the marketplace, with the methods of restraint inevitably subject to competing claims concerning safety, effectiveness, and therapeutic value. These claims are seldom underpinned by valid, empirical evidence and, as Allan (1998) suggests, are often accepted solely on the basis of the reputation of the institution or trainer. In a review of the early literature, Fisher (1994) concluded that "seclusion and restraint work." A more recent analysis of available research cited a range of beneficial outcomes but concluded, "Unfortunately, the research indicates none of the above outcomes can be guaranteed from training, and negative results have also been observed in each of the above areas." (Allen, 2000). Some training programs appear to actually increase risk.

Research in this crucial area remains inadequate. The complex etiology of aggression makes it difficult to isolate the impact of staff training as a specific variable. Chronic underreporting and an absence of reporting mechanisms at agency, state, and national levels have done nothing to end a historical climate of invisibility and complacency in which high-risk restraint techniques continue to be used and promoted.

Defining the problem solely as an issue of staff skill may actually increase incidents and reinforce the prevailing blame and power culture so prevalent in many agencies.

Violence in the human services is clearly a complex phenomenon. As many authors suggest (Gunn, 2000; Paterson & Leadbetter, 1999), agency ethos is the strongest predictor of assault and restraint usage. Consequently, the prevailing "reductionist" approach of many violence-management training programs, which emphasize the interpersonal skills of deescalation and restraint, is to locate the problem within a faulty paradigm. Defining the problem solely as an issue of staff skill may actually increase incidents and reinforce the prevailing blame and power culture so prevalent in many agencies.

Investigative journalism has opened Pandora's box. The state television service exposed the U.K. government's lack of policy (British Broadcasting Corporation, 1999). Consequently, with state funding, the British Institute for Learning Disability has developed a range of initiatives including a policy framework (Harris, 1996), a research overview (Allen, 2000), a Code of Practice (Allen, 2000), and an accreditation framework for training providers underpinned by more explicit government guidance. Concerns remain about the commitment, robustness, and coherence of such measures and the lack of comparable guidance for other service sectors and U.K. national jurisdictions, such as Scotland.

The U.S. Food and Drug Administration estimates upwards of 100 restraint-associated fatalities per year. Publication of the *Hartford Courant* (1998) database, which outlines restraint-associated fatalities in human services from 1988 onward, has, however, spurred congressional action. A three-year, five-site study funded through the Office of Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services will focus different behavioral management and restraint training models. The coordinating body will be the Child Welfare League of America, which has already issued comprehensive "best-practice guidance" (CWLA, 2001). These guidelines must be considered carefully, however, as the vendors and users of restraint training programs from the United States acted as members of the task force's advisory committee.

Each site will assess its own program independently. Inevitably, we must

consider the Hawthorne Effect, which suggests the act of examining an issue influences the phenomenon observed. As research has shown, levels of restraint are inevitably reduced merely as a consequence of making this an explicit aim of a program. The projects' lack of a uniform, independent evaluation strategy may therefore detract from the robustness of its conclusions.

Although determined by many factors (Paterson and Leadbetter, 2000), the mechanisms of injury in restraint remain the subject of heated debate, unsurprising given the potential liability consequences. Despite the inadequacy of the research base, there is arguably a consistency in emergent conclusions and advice. The key factor in the equation, which many appear reluctant to consider, remains the question of the actual method of restraint. Half of the deaths outlined in the *Hartford Courant* database had a known methodology, and of those:

- 49% were attributed to the act of "going to the floor"
- 31% involved prone restraint
- 11% involved take downs
- 3% involved basket holds

Various authoritative sources suggest the enhanced risks of specific techniques, which include basket holds, prone/supine restraint, pressure across joints (for example, straight arms), and pain compliance. (for example, CWLA, 2001; Department for Education and Skills, 2002; Department of Health, 2002; Department of Health/Scottish Office, 1996). CWLA guidance specifically lists prone restraint as a high-risk factor. Yet such techniques remain widely employed across the human and childcare services, potentially including those in the SAMHSA project.

We must avoid cynicism, however, and welcome the belated inclusion of restraint within professional and social policy agendas. The real danger is that the process obscures the product, and the hard questions remain unasked. For example, why is the emerging evidence about high-risk methodologies failing to inform our review of existing training programs in this area of care? Who should make the decisions about what constitutes best-practice guidelines in this vital area? Should the training vendors and users, who may have a vested interest in maintaining current practices, be providing the solution for our industry, or should research and medical information form the basis of our decisions? To what extent is the evidence guiding us in developing the safest, most effective physical intervention techniques? What are the implications for the federally funded grant projects using existing training programs that employ techniques that may carry an enhanced risk of injury? Are we really advancing the field with our collective knowledge, or are we inadvertently doing more of the same while expecting different results?

To reduce the deaths and injuries associated with restraint we must adopt a coherent long-term strategy. Understanding the mechanisms of injury requires effective injury reporting and auditing. The post hoc analysis of injury patterns is unlikely to provide definitive data, however. This will require the proactive analysis of specific techniques against accepted medical and biomechanical criteria. But safety concerns must also be balanced by a concern with the social validity of specific restraint techniques. Surveys of service users suggest restraint is invariably a degrading and disempowering experience, often described as tantamount to rape (Blanch & Parrish, 1992). Consequently, the development and regulation of safe practice must also involve a meaningful dialogue with service users and the subordination of commercial and vested interests to an open debate and the adaptation of practice on the basis of emergent conclusions.

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Girls and Boys Town: Empowering Children

by Paula Jones

Girls and Boys Town has partnered with a large county-operated emergency shelter to reduce and prevent the use of unnecessary restraint and seclusion. A leader in the treatment and care of at-risk youth, Girls and Boys Town has helped many organizations to meet the ever-changing needs of children and families.

Because of Girls and Boys Town's outcomes-based treatment approach, children and families nationwide are learning skills to overcome their problems and live better and happier lives. In 2001, Girls and Boys Town directly helped more than 37,000 children. The organization touched another 1.5 million lives through its national hotline, outreach, and training programs.

The partnering program is a 24-hour temporary emergency shelter for children who must be separated from their families for their own safety because their parents have neglected them or cannot provide care due to incarceration or other extenuating circumstances. The shelter has seven cottages on a campus that can house up to 192 children. It served more than 3,900 children from July 1, 1999, through June 30, 2000, from infancy through age 18.

The population's primary referral problems include physical abuse, sexual abuse, drug and alcohol abuse, neglect, and caregiver issues. Like children in many other welfare agencies, those placed in the facility for these referral problems also present numerous mental health issues resulting in dangerous behaviors, at times requiring physical intervention.

The services Girls and Boys Town provides to the partnering agency are designed to move the program philosophy from one of punishment and control to one based on strength and self-control. To make a significant lasting impact and lower incidents of restraint and seclusion, the shelter is implementing a systems approach addressing training, supervision, evaluation, administration, and audit.

Girls and Boys Town hopes to empower children with skills that will allow them to build relationships with others, and deal with conflict and disappointment in appropriate ways, as well as provide them with self-calming strategies. By fostering these skills in our youth, we should be able to decrease the need for restraint and seclusion.

To provide skill-building activities for children, direct-care staff must use a consistent teaching curriculum, with similar tolerances for youth behavior. The teaching curriculum provides staff with the tools to teach youth prosocial behaviors as well as verbal deescalation techniques to use when a youth loses self-control. Staff are able to respond rather than simply react to stressful situations with children. This decreases the possibility that staff may escalate the situation and use unnecessary controls to manage youth behavior. This teaching curriculum will supplement existing approved physical restraint and seclusion techniques rather than provide training of physical practices.

The services Girls and Boys Town provides are designed to move the program philosophy from one of punishment and control to one based on strength and self-control.

Once direct care staff are trained, effective supervision is important to strengthen the training effects and sustain the skills that staff have learned in training. Effective supervision requires mastery of the teaching curriculum along with the acquisition of supervisory skills. These skills include providing on-the-job coaching and support, accurate identification of staff strengths and weaknesses, staff reinforcement and correction techniques, and monitoring and responding to crisis situations. Additionally, supervisors receive several data collection and analysis tools to assist with their supervision activities.

Supervisor accountability is paramount to program success. Supervisors are required to engage in activities including staff observations, documentation of staff development, crisis debriefing, and regular meetings for disseminating critical information. In turn, supervisors are required to document these activities. The agency has received tracking instruments, and supervisors receive monthly feedback about their adherence to the supervision schedules and the quality of their consultation.

To create and maintain such an environment, administrators must embrace a strength-based, empowerment-oriented child care philosophy. This philosophy can be supported only with a shared vision for all departments that begins with the development of program policy and procedures. Girls and Boys Town consultants assist the agency with policy and procedure development and with the integration of program services, including behavioral, clinical, educational, and medical services. They also assist in data collection and analysis to ensure intradepartmental cooperation, goal achievement, and alignment with the program mission.

To maintain the noncoercive environment after services have ended, Girls and Boys Town is helping the shelter develop audit protocols to review serious incidents including all instances involving restraint and seclusion. To do so, the system requires clear reporting protocols for staff, defined youth rights, objective reviewers, and a consistent inquiry process. In addition to incident review, an effective audit system requires a data

management system to track incidents. Girls and Boys Town is helping to develop a systematic analysis of incident trends. Through ongoing consultation, administrators will learn to identify relevant data points and trends, explore explanations of trend data, and develop action plans in response to the data.

By establishing a proactive, strength-focused philosophy with training, supervision, evaluation, administration, and audit systems, Girls and Boys Town intends to help the partnering shelter reduce the use of physical controls and improve the quality of care for thousands of children.

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Courageous Patience:

Implementing Continuous Quality Improvement to Reduce the Use of Restraint and Seclusion

by Robert W. Plant

"Good ideas are not adopted automatically. They must be driven into practice with courageous patience."
—Admiral Hyman Rickover

In March 1998, a young boy died while being restrained at a private psychiatric hospital in Connecticut. An investigation by the *Hartford Courant*, and the newspaper's subsequent inquiry into similar deaths across the country spurred a critical look into the use of restraints and seclusions (restrictive treatment interventions or RIs) in facilities providing treatment to individuals with behavioral and psychiatric disorders.

The national attention brought to this issue led to the development of regulations, laws, and practice guidelines regarding the use of restraint and seclusion in psychiatric settings. Following the lead of the Center for Medicare and Medicaid Services (CMS), many groups either adopted regulations or published practice recommendations regarding the use of RIs, including the American Academy of Child and Adolescent Psychiatry, the Child Welfare League of America, the Joint Commission on the Accreditation of Healthcare Organizations, the National Association of State Mental Health Program Directors (NASMHPD), and numerous state governments.

Before RIs received national attention, a number of psychiatric facilities throughout the country, including one state-operated public psychiatric hospital, Riverview Hospital for Children and Youth in Middletown, Connecticut, embarked on a program to reduce the use of RIs through a series of strategically linked quality improvement interventions. Beginning in 1996, the hospital administration became concerned about what seemed to be high rates of restraint and seclusion. A literature review revealed very few empirical studies on restraint and seclusion, and even fewer focusing on children and youth. Initial efforts to improve staff training by expanding the verbal deescalation portion of the behavior management curriculum resulted in an increase in restraints and seclusions rather than the expected decrease.

Following their unsuccessful attempt to reduce RIs through improved training, the hospital administration and clinical leadership spent months reviewing their own clinical experiences regarding which practices prevented RIs and which were associated with high levels of RI use. They noted a trend toward strict behavior management that had contributed to a more punitive and consequence-based therapeutic milieu. They concluded that many staff efforts to control aggression and achieve behavioral compliance increased the number of power struggles between staff and patients. The emphasis on control and use of coercive interventions was believed to be contributing to high rates of restraint and seclusion. The hospital staff observed what appeared to be a "coercive cycle" (Patterson, 1975) where patient aggression and behavioral noncompliance were met with the staff's increased attempts to control behavior. The increase in control led, in turn, to increased acting out. The milieu needed to be completely redesigned to reduce the emphasis on compliance and increase the frequency of positive and autonomy-supportive interactions between staff and patients.

In the fall of 1999, a multidisciplinary workgroup composed of children's services workers, nurses, nurse managers, rehabilitation therapists, psychologists, social workers, psychiatrists, and members of the nursing and clinical leadership began the task of milieu redesign. The group drew heavily on the work of Brendtro (1988) and Ryan, Deci, and Grolnick (1995) for the theoretical basis of their approach. The resulting treatment philosophy stated that by creating an environment that supported the fulfillment of core needs, conflict would be reduced and internal control of behavior would be promoted. The core needs were identified as Autonomy (self-determination), Belonging (attachment or relatedness), Competence (mastery), and Doing for Others (generosity). Thus, the ABCD program was born.

Staff efforts to control aggression and achieve behavioral compliance increased the number of power struggles between staff and patients.

The ABCD program emphasized the relationship basis of all forms of intervention and focused on methods of engagement, particularly the role of coach. The coaching component involved daily assignments of direct care staff to work with children individually or with two to three children or youth in small group activities at designated times in the program schedule, allowing coaching to occur several times a day. The coaching role emphasized proactive engagement in contrast to a reactive disciplinary orientation where contact occurs primarily when kids act up.

The program also strove to deemphasize the behavioral point system that, at

its worst, could degenerate into taking points away for each rule infraction or act of noncompliance. Twice-daily feedback was structured to emphasize patients' accomplishments and the qualitative elements of their behavior rather than a numerical summary of points earned. Where "consequences" for behavior were often punitive in the old program, ABCD introduced learning tasks. Learning tasks attempt to use episodes of problem behavior as teachable moments and as prompts for problem identification and skill development. The ABCD mnemonic was introduced as an easy way for staff and patients to keep general treatment goals in clear focus. All interactions, treatment interventions, and program rules were explained in terms of their support of or relationship to the ABCDs.

The workgroup developed a two-day training curriculum and program manual. Before rolling out the program to each of the eight hospital units, the administration saw an opportunity to test some of the concepts embodied in the program philosophy. In May 2000, in collaboration with Martin Lynch and Richard Ryan of the University of Rochester, a staff survey was administered to 180 of the hospital's 400 full- and part-time staff. Also, 90 of 100 patients were administered a self-report questionnaire. The plan was to repeat both the staff and patient surveys every six months for two years to measure any changes associated with the new milieu.

The staff survey was designed to measure a host of organizational climate factors believed to be relevant to RIs, including demographic factors, staff's autonomy orientation on a continuum from controlling to autonomy-oriented, staff history of injury related to patient aggression, staff morale and well-being, and staff perceptions of personal autonomy in their jobs and support of autonomy from the administration. The patient survey produced a rating of patient perceptions of the nature of the hospital environment, from "autonomy supportive" to "controlling."

Over a period of six to eight months, approximately 80% of the staff completed training on the new program. Fairly soon after its implementation, the administration recognized that two days of staff training would not be sufficient to cause or sustain significant changes in the way the milieu was functioning. Units began to drift back toward their customary ways of operation. Adopting a method from Multi-Systemic Therapy (Hengeller & Borduin, 1990), the hospital developed a program fidelity measure and developed program consultants to spend time on each unit, rate the unit's

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fidelity to the program, and provide feedback to the unit leadership on where the unit was being true to the program and where it needed to improve. Fidelity ratings were completed on a periodic basis and continue to be administered.

During the initial period of program rollout, restraint and seclusion were reduced to some extent. In search of more significant results, the hospital decided that a more direct approach toward reducing restraint and seclusion was required as an adjunct to the new milieu. Based on the notion that self-monitoring is often the first step in behavior change and that self-monitoring alone can produce results, the hospital implemented the *Unit Dashboard,* simply a method of providing regular weekly feedback to each unit on key indicators of performance, including use of restraint and seclusion. The *Dashboard* was distributed to the leadership in each unit and posted in an area for all staff to see. We recommended the *Dashboard* be reviewed as part of a regular weekly staff meeting.

Around the same time, late in 2000, the hospital created a steering committee to promote staff input in running the hospital and to strengthen staff autonomy. Individuals from each hospital department and shift were elected by their peers and met monthly to share ideas on how the hospital could be improved. Attendance, although initially high, fell off after several months, and after two years the elected format and monthly meetings were replaced with a series of issue-focused "town meetings" or forums attended on a voluntary basis.

Following implementation of the *Unit Dashboard*, and with the help of Behn's (1991) research on strategic management, the hospital administration worked with each unit to set goals to reduce restraint and seclusion. Three years' worth of data were reviewed, and ambitious but realistic goals were set for each unit, aiming for a roughly 50% reduction in the use of restraints the first year.

Goals were set low during the first months, then gradually increased to maximize the likelihood that units would have initial success. The hospital agreed to provide $50 of flexible funds to each unit that met its monthly restraint goal. The money could be carried over from month to month and used to purchase items that would enhance the unit environment for patients and staff, such as DVD players for the unit, a pizza party for patients and staff, and pots and pans to be used to cook special meals with the patients and their families.

Many units met their monthly goals consistently in the first year, although some were less successful.

Staff response to violent behavior lacked consistency, and from the perspective of the patient, a very confusing message was being delivered.

Administration stopped publishing the names of successful units in the hospital newsletter after hearing that the units who were not meeting their goals felt pressured by their notable absence. Because the hospital wanted to promote autonomy among staff, a concerted effort was made to avoid the perception that rewards were meant to be controlling. Ryan (1982) demonstrated that rewards could be perceived as information that provides competence-related feedback or as controlling tools that represent pressure toward a particular outcome. In recognition of these findings, the size of the tangible reward and the nature of the feedback were designed to maximize the informational salience and minimize the controlling aspects of the rewards.

In January 2001, the hospital began implementing the CMS regulations, including the so-called one-hour rule that required individuals to be evaluated by a licensed independent practitioner (LIP) within one hour of being placed in restraint or seclusion. At Riverview, the LIPs were physicians. Although the rule increased physician involvement in RIs and raised the level of monitoring, the hospital continues to question whether it has been effective or efficient in reducing restraints and seclusions.

To address staff concerns about continued high rates of violence, the hospital determined that every unit needed to incorporate a structured impulse control program that would teach children and youth the skills necessary to improve control over their own behavior. The In-Control Curriculum (Kellner, 2001) was rolled out to units one by one.

The hospital noted that staff response to violent behavior lacked consistency and that, from the perspective of the patient, a very confusing message was being delivered. Depending on the unit, shift, staff assigned, or day of the week, responses to similar acts of violence under similar circumstance were dealt with differently. A structured approach to dealing with violent behaviors was necessary, and through the work of the newly developed Prevention Committee and Community Safety Committee, the Intensive Care Plan (ICP) for Violence was created. First, the hospital constructed a "no-tolerance for violence" statement that was posted throughout the hospital. The statement indicated that violence would be swiftly and appropriately addressed and that the aim was to promote an environment that protected the dignity and well-being of all persons. The patient council endorsed the antiviolence statement.

The next step was to operationally define "violent behavior." The committees identified three levels of violence—verbal threats, property destruction

or menacing, and physical assault. Structured responses were developed, including required restrictions and relevant learning tasks consistent with the impulse control language and approach. Three developmental levels of response were implemented, one each for older adolescents, younger adolescents, and younger children. The approach was field tested on two units and further modified.

The committees identified three levels of violence—verbal threats, property destruction or menacing, and physical assault. Structured responses were developed, including required restrictions and relevant learning tasks consistent with the impulse control language and approach.

A key component was the inclusion of helpful worksheets for learning tasks that could be accessed quickly and easily following a violent act. Instead of reinventing the wheel each time an incident occurred, the staff could be guided by a structured approach that taught skills and promoted empathy.

As the hospital continued to monitor implementation of the ABCD program and conduct regular fidelity assessments, it became evident that consultations and feedback were occurring at the unit level. Although this was helpful, problems persisted at the individual staff member level. As the hospital continued to conduct unitwide assessments, further change seemed unlikely without an emphasis on individual supervision.

In early 2002, the hospital resurrected a defunct supervisory position known as the Lead Children's Services Worker. Until this point, nurses performed most supervision of direct care staff. As the nursing shortage worsened and nurses became focused on traditional nursing duties, such as administering medication, clinical assessment, and physical health care, their availability to provide supervision declined. The hospital identified the most talented children's service workers and selected those who were most knowledgeable and supportive of the ABCD program. The leads received supervisory training and participated in weekly group supervision.

At the same time the hospital received the SAMHSA award, its leaders decided the best way to further reduce restraints and seclusions was to extend the ABCD training and develop a new training model that would be less likely to compete with direct care responsibilities. The plan was to extend and enhance the ABCD program by teaching the core skills necessary to support and promote autonomy, belonging, competence, and doing for others. At the same time, core competencies and performance evaluation tools would be modified to be consistent with the training goals and content. Training and supervision would be linked through the role of the lead children's services workers.

The training model is being modified to move from periodic concentrated training events to short weekly training sessions that can be more easily transferred into practice. Since January 2003, 45-minute training sessions have been provided three times each Monday, Tuesday, Thursday, and Friday. The same training session is offered 12 times each week, providing staff with multiple opportunities to attend. The training sessions will provide staff with core knowledge and skills necessary to provide the highest level of care.

Topics may include various coaching techniques and activities, knowledge of child development, understanding various diagnostic labels, conflict mediation, clarification of important policy, and similar topics. Whenever practical, sessions will be structured to allow participants to practice what they have learned and to incorporate the existing expertise and insight of the most talented employees. Training sessions will be reinforced on the job through the supervision provided by lead children's services workers.

Restraints and seclusions declined nearly 60% during the period in which these interventions were employed. Although we cannot identify which, if any, of the interventions were responsible for the changes noted, it appears to confirm our efforts' success. Keys to success appear to be:

- **A strong commitment to reducing restraint and seclusion while maintaining safety.** The hospital encountered significant staff resistance to the changes in the milieu and other interventions. We needed to demonstrate "courageous patience" in the face of this resistance and to maintain a strong commitment to our goal; we could not be discouraged by the lack of early results or the failure of some of our interventions.
- **Employment of multiple methods and strategies.** Our experience has been that no single approach or strategy is likely to be effective in reducing restraints and seclusions.
- **Continuous database assessment.** Monitoring, tracking, providing feedback, and organizing data have been key in driving and modifying practice. In our experience, the empirically based goal setting, *Unit Dashboard* monitoring, ABCD program fidelity ratings, staff survey data, and the collection of related data on episodes of violence, injuries, and police involvements were all key features.

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Courageous Patience

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• **Combination of direct and indirect approaches.** Riverview's approach to this problem included direct strategies to reduce restraint and seclusion (goals and CMS rules) as well as indirect approaches (ABCD program and SAMHSA training). The experience has shown that direct approaches produce early tangible results that build confidence, whereas indirect approaches address the underlying factors that require change for lasting impact.

Training had to be redesigned to be more practical and interfere less with the need to provide direct care.

• **Supervision and training.** Supervision has emerged as a critical factor in achieving lasting change in staff behaviors believed to be related to rates of restraint and seclusion. We also recognize the interdependence between training and supervision.

Our approach to training had to be modified to maximize transfer of skills to the unit-based work. Training also had to be redesigned to be more practical and interfere less with the need to provide direct care.

Efforts to reduce the use of restraint, seclusion and other restrictive treatment measures will require persistence and courageous patience to be successful. Through the efforts of organizations such as SAMHSA, CWLA and the NASMHPD, the field is beginning to identify those practices that most effectively reduce our reliance on restrictive treatment interventions.

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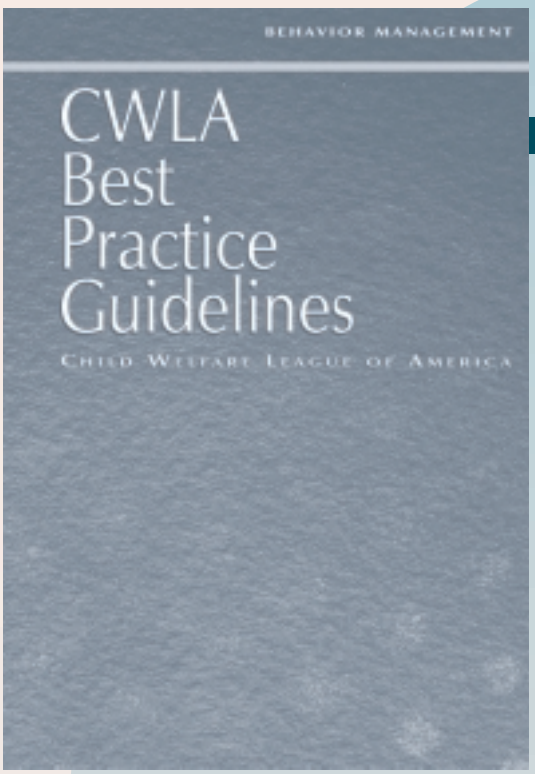

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