Crossing Systems to Achieve Better Outcomes:

A Collaborative Approach Toward Prevention of Seclusions and Restraints

Presented by Adelbrook:

Julie Piepenbring, PhD, LCSW

Alice Simoniello, LCSW

Stephanie Maynard, LCSW

Paul DiPietro, BS

Overview

- Services Provided: Residential, Community, School
- Autism Spectrum Disorder and other Neurodevelopmental Disorders





Transformative Process

- Treatment Perspective: Applied Behavior Analysis, OT, TR etc.
- Introduction of new Roles; Behaviorists, later on BA,BL, BT
- Staff/Clinicians –turnover during the transitional period
- New specialized programs and services developed
- Change from Therapeutic Crisis Intervention (TCI) to Physical and Psychological Management Training (PMT)

Population

- Major Change in Population
  - 2011 changed from behavioral and emotional disturbance to Autism Spectrum Disorder and other Neurodevelopmental disabilities
  - 50% of current residential population with nonverbal or severely limited functional communication skills
  - Increased medical conditions
  - Enhanced need for interdisciplinary approach

Purpose of Presentation

- Application of the framework of the Six Strategies of Restraint/Seclusion Reduction (NASMHPD, 2006)
- Integration of our philosophy, organizational modalities and clinical tools
- Managing the realities of our work
  - Normalizing the process of organizational change
  - Accepting the evolutionary process of change

Components of Change

Vision
Empowerment
Tools
Creativity
Flexibility
Collaboration

What does the staff think????

- Thematic results showed need and DESIRE for additional training
- Lack of knowledge about youths with ASD
- Didn’t feel confident working with youths with impaired functional communication skills

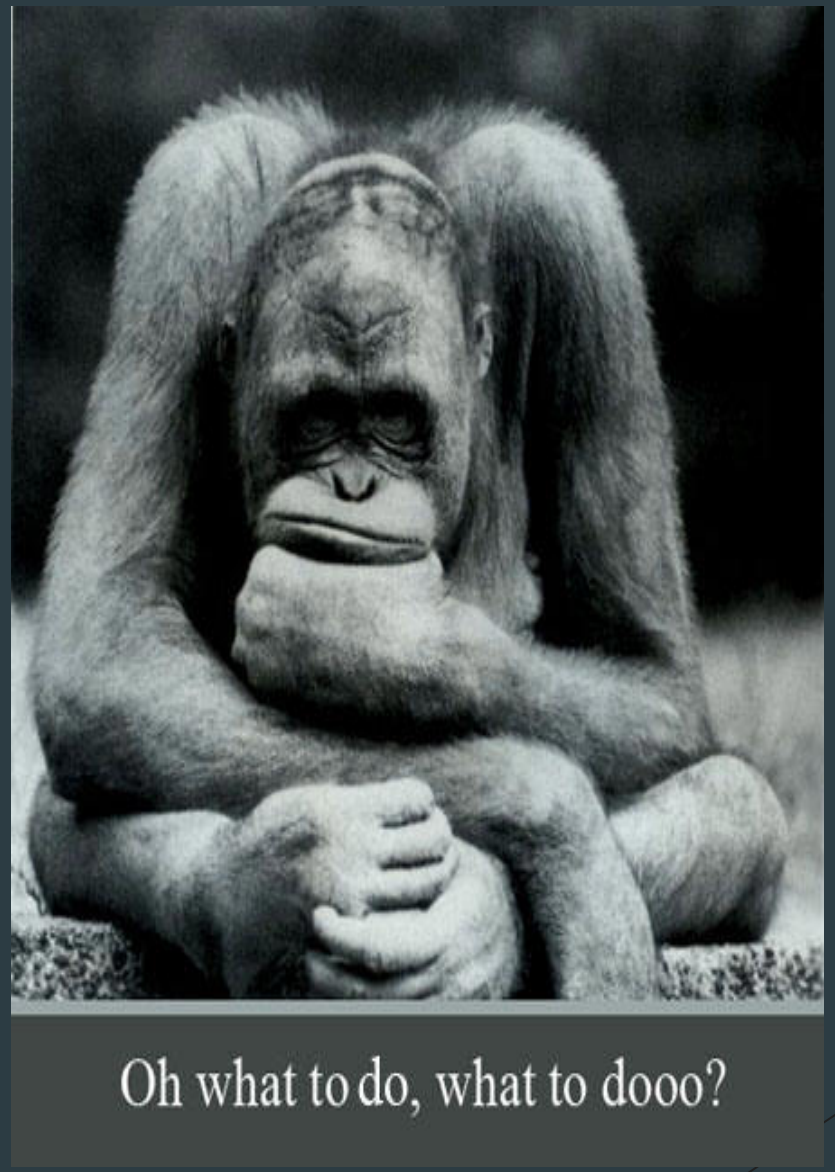
Where did we start?…or START

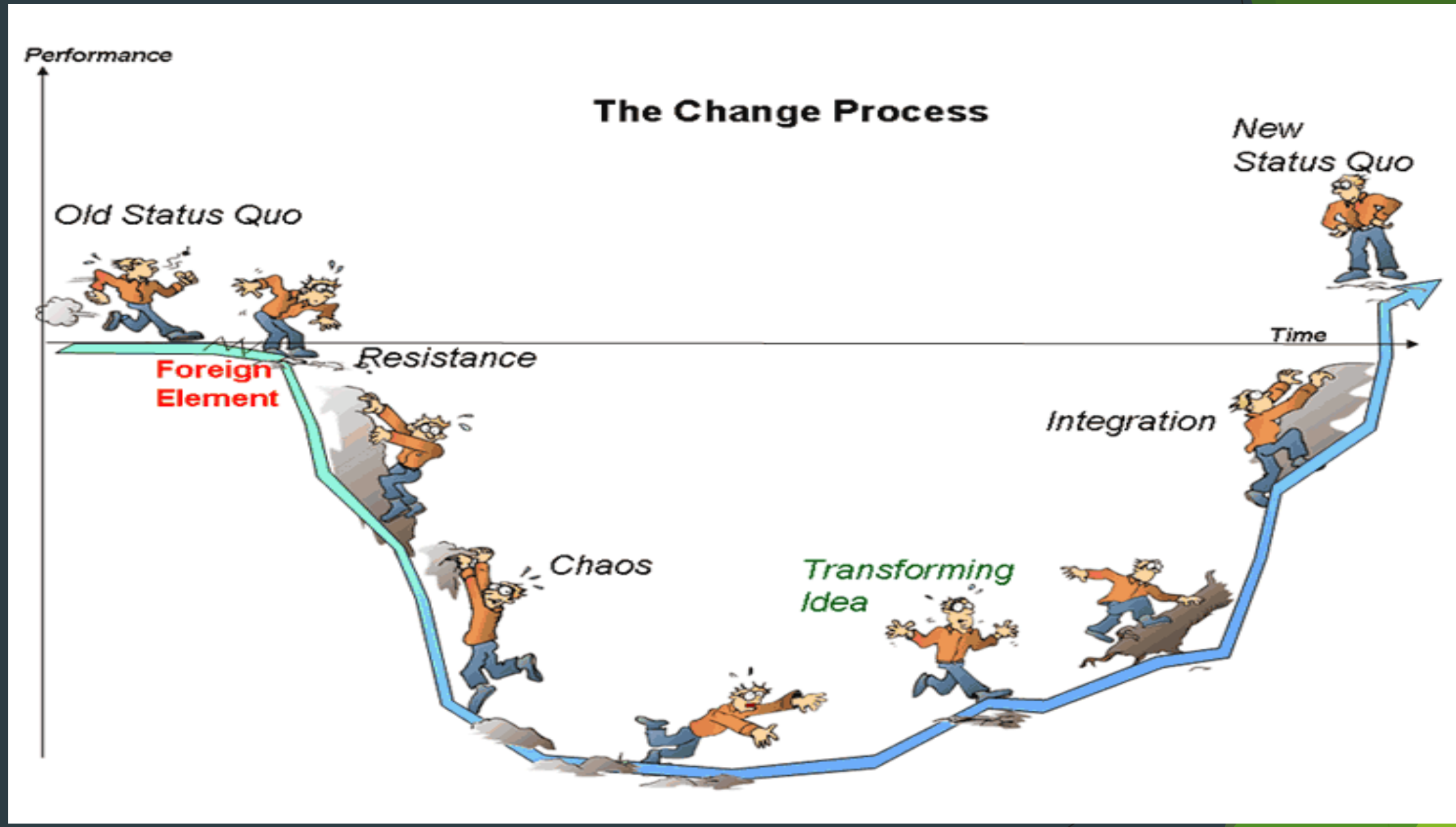
- Systemic Treatment Assessment and Respite Treatment (START)
- Where our paradigm begins to shift about treatment for our population
- Intensive training
- Tool: Cross Systems Crisis Plan (CSCP) – J. Beasley, 2007

Organizational Change

We determined that there will be NO MORE RESTRAINTS

Imminent Risk was defined collaboratively: medical, clinicians, direct care, behaviorists, occupational therapists

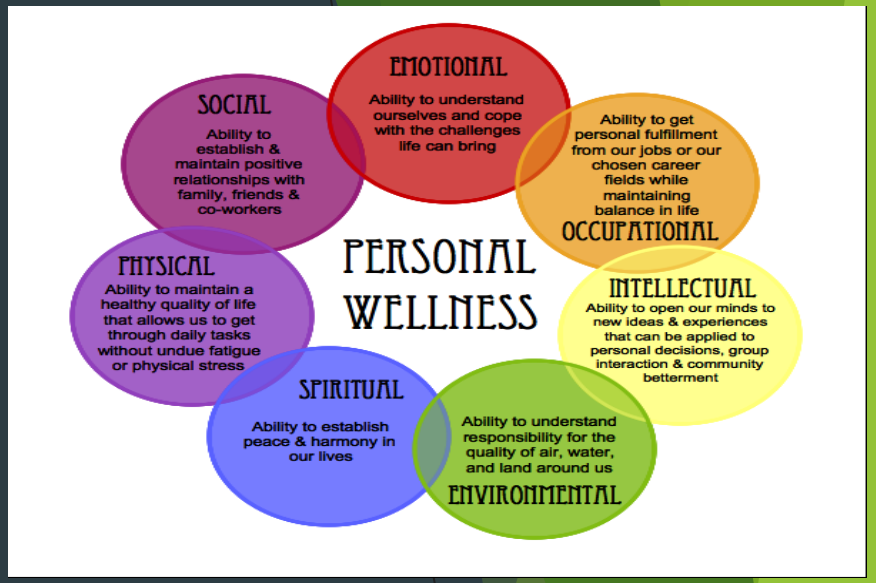



Performance
The Change Process
New Status Quo
Old Status Quo
Time
Foreign Element
Resistance
Integration
Chaos
Transforming Idea

Limitations

- NOT a research study
- Lots of other variables at play

Cross Systems Crisis Prevention and Intervention Plan and Workforce Development



- 1 of 6 core strategies of R/S reduction

- *addresses one of the central components of the*

6 CORE STRATEGIES developed by the National Association of State Mental Health Program Directors (NASMHPD)…WORKFORCE DEVELOPMENT

- The CROSS SYSTEMS PLAN is a

three dimensional document-

developed by Joan Beasley, PhD. (2007)

- The CROSS SYSTEMS is a *person-centered intervention* that focuses on the "*principles of recovery, choice, respect, self-management and full inclusion" (NASMHPD, 2006,p.2)*.

Poly-Authored Document

- *Spans across SYSTEMS to bridge service delivery gaps*
- *In-Depth Snap-shot of an individual and his/her needs*
- It takes a closer look at the individual's **strengths, resources**, history, patterns of behavior, and past successes, *AS WELL AS* areas in which they have **struggled** or which have led to hospitalization or placements.

Out With the Old…In With The New

Previous Tool- ICMP

- *one-dimensional document*- captured the basics

- Was authored solely by the clinician

- *REACTIVE* plan…what to do when the youth presented with various behaviors.

They tended to be one page …were brief…not a collaboratively informed tool.

Old Crisis Plans

Individual Crisis Management Plan	
Youth Name: Youth	**Date: 10/3/13**
Youth's Strengths (What am I good at? What do I enjoy?): Youth is verbal and when at baseline communicates well with others – has good expressive language skills, however struggles with receptive language skills. Youth has been known to enjoy being in the "caregiver" role and enjoys interacting with babies. He has a variety of activities he enjoys including swimming, playing legos, playing video games, going on community outings, playing drums and interacting with animals.	
Triggers (What makes me feel upset?): Triggers for Youth include when demands are placed upon him, when he is prevented from doing a preferred activity, lack of structure, when transitions take place, a change in his schedule or routine, when he is unable to independently complete an activity and is feeling discouraged, when he is rushed, when there is too much complicated verbal direction being given to him, crowds and when he is over-stimulated by a noisy or chaotic environment. Other triggers include toileting issues, heights, morning routines, having physical contact with others without warning, and touching his items without permission. He also has difficulty during times of visits with his family.	
Warning Signs (What happens to my body?): Youth may show a variety of warning signs including yelling and swearing or throwing items, slapping his leg and breathing more forcefully and looking frustrated	
Current Issues: (personal/family/social): Youth has diagnoses of PDD-NOS, ADHD combined type, PTSD as well as fetal alcohol syndrome and in utero exposure to polysubstance which has significantly impacted his trajectory and past and current functioning and behaviors. Youth has been hospitalized multiple times for unsafe behaviors and has also received intensive in home and community supports which have been unsuccessful in assisting to manage his behaviors for any extended period of time. Due to the severity of his behaviors he is unable to be managed in his home environment where he previously lived with his adoptive parents. Youth also has a history of being sexually exploited by an older adoptive sibling.	
Behaviors of Concern: Youth's behaviors including physical (hitting, biting, kicking, scratching, head butting), and verbal (swearing, yelling) aggression, self injurious behaviors (banging head on object or with hand, biting himself), as well as sexualized behaviors (touching himself inappropriately or dancing in an appropriate nature in front of others) and encopresis.	

Safety Tools (What helps me feel better? Include sights, smells, sounds, touch, tastes):
In the Triggering Phase: When working with Youth, staff should use a calm and neutral voice and should use a "would you rather do this or that" or "can you help me with this" approach instead of using a "you need to do this" approach. Staff should also use a "first" and "then" approach to let him now about events in his schedule. Staff should also use simple and consistent language when working with him as too much verbal language can also be a trigger for him. Also, staff should provide him with time limits in order to avoid difficulties around transitions. If triggered staff should encourage him to use his words to indicate what is wrong and offer him praise if he appropriately uses his words. If he continues to be triggered staff should try to use redirection and distraction. At times he responds to humor. He should also be encouraged to utilize sensory activities that may calm him down. As little attention as possible should be given to behaviors while also ensuring his and others' safety.
In the Escalation Phase: Youth should be prompted to take a break and take space, while staff keeps him in line-of-sight arms length since he will be on a 1:1 in order to monitor his affect and behaviors and manage the environment for items that may be unsafe. His 1:1 staff member should take the lead and maintain simple and straight forward language. Staff can also remind him of the reinforcers he is working towards.
In the Outburst Phase: Once Youth has been given space and if he is calm, he may re-enter the activity. If Youth escalates to the point in which he presents imminent risk of injury to himself, AEB head-banging, biting, the least restrictive TCI safety intervention strategies may be used as well as agency crisis management interventions. Youth may be at imminent risk when he engages in self-injurious behaviors such as head-banging. With regard to aggression toward property or others, environmental management strategies should be used. If environmental management strategies are unsuccessful and he presents imminent risk to others including aggression towards others, the least restrictive TCI safety intervention strategies may be used as well as agency crisis management interventions.
In the Recovery Phase: Once Youth is calm, address the incident through an abbreviated LSI and transition Youth back into an activity and monitor his affect and behaviors.
Emergency Contacts: **DCF Social Worker: _XXXXXXX, Adelbrook Clinician:_XXXXXXX, _____**
Review date for ICMP: 10/3/13
Changes Made: added additional triggers and warning signs
Signatures: **Resident: _____ Date: _____** **Parent/Guardian: _____ Date: _____** **House Staff: _____ Date: _____**

- CSCPIP replaced Individual Crisis Management Plan

CSCPIP

- Preventative versus Reactive
  - Difficulties occur in stages
- New Plan is **Collaborative**
  - Poly Authored
  - Interdisciplinary Approach
  - In sync with BIP, OT, Medical etc.
- Biopsychosocial Perspective
- Strengths/Deficits

Ädelbrook Behavioral and Developmental Services
CT START Center for Children & Young Adults

Cross-Systems Crisis Prevention and Intervention Plan
PART I - FACE SSHEET
Demographics

Name: Youth
Date: 6/10/16
D.O.B.: 00/00/0000
Telephone #: 00000000
Address: Adelbrook –Shiloh House 60 Hicksville Road, Cromwell, CT 06416
Family- Mom and Dad

Living Situation (check appropriate box):

__ lives with family
___ lives alone with supports
__ lives alone
X lives in Adelbrook residence

Description: Youth lives in Adelbrook's residential program, Shiloh House.

- Diagnosis
- Current Medications
- Medical Concerns
- Communicative Style
- Strengths/Skills/Interests
- Provider List

- Describe general patterns of behavior, personality traits (i.e. has a good sense of humor, does best when Takes space)
- Describe environment in which individual lives
- Describe factors that create increased stress for individual (i.e. holidays, anniversaries)
- Describe nature of any legal involvement
- Describe situations and/or behaviors that have historically led to hospitalization for the individual
- Describe alternatives that have been effective in keeping the individual out of the hospital
- Specify what options have been most successful in the past
- Emergency back up plan
- Factors that lead to increased stress

CSCPIP

Stage I	early signs		least restrictive intervention	
Behaviors/Signs/Symptoms	Biopsychosocial Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #'s
1. When Frustrated, Youth will screech and grunt. 2. May bang arm on table 3. stomps foot 4. may begin to toss items 5. Increased stimming behaviors: hand flapping 6. Retreats to room. 7. Often prior to engagement in maladaptive behaviors, Youth will begin to breathe forcefully (i.e. huffing and puffing) with a frustrated look on face.	Poor expressive language skills- primarily non-verbal Low frustration tolerance Difficulty processing Difficulty regulating emotions. ASD Trauma history Sexual abuse history Mistrust of others Separation from mother and family	1. Being told "no" 2. Uncertain about what is next 3. Unpreferred staff 4. Task demands 5. Feeling pressured or rushed 6. Lack of structure	1. Taking space in quiet area 2. Try sensory interventions (deep pressure, weighted blanket). 3. Practice deep breathing technique 4. Use simple words and then give time to process. 5. Try to distract with another activity. 6. Provide with pre-determined choices to allow him/her to feel empowered. 7. When at this stage, Youth will tolerate and at times respond well to humor. 8. Remain calm in tone and body language.	House Staff Behaviorist Behavioral Associate Clinical Coordinator Medical department Mother DCF worker

CSCPIP

Stage II	increased intensity		Increased level of intervention	
Behaviors/Signs/ Symptoms	Biopsychosocial Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #'s
1. Youth may begin to throw objects 2. May flop to floor and refuse to move. 3. May try to leave a supervised area. 4. May put both hands up towards staff as if to push them. 5. Ignores others 6. May lightly bang head	Seizure Disorder Poor expressive language skills- primarily non-verbal Low frustration tolerance Difficulty processing Difficulty regulating emotions. ASD Trauma history Sexual abuse history Mistrust of others Separation from mother and family	1. loud or stimulating environment. 2. When not getting his/her way 3. When hungry 4. Pre-or post seizure	1.Call medical dept to assess in case of seizure. 2. Use minimal language in this stage. 3. Use proximity, give space. 4. Use line-of-sight (LOS) protocol, b/c if one begins to approach Youth before ready he/she may attempt to kick, bite, hit (stage III behaviors). 5. Safely manage the environment and attempt to decrease access to objects . 6. Try sensory strategies (weighted blanket, deep pressure) 7. Practice deep breathing technique 8. Reduce talking 9. go for a walk 10. The presence of certain staff helps de-escalate and feel safe. (esp females who are soft-spoken and have a caring demeanor)	House Staff Behaviorist Behavioral Associate Clinical Coordinator Medical department Mother DCF worker

CSCPIP

Behaviors/Signs/ Symptoms STAGE III	Biopsychosocial Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #'s
1. Youth will begin hitting others; hitting the walls 2. May hit head forcefully 3. Hit staff 4. Kick, punch, attempt to bite others 5. Will attempt to leave a supervised area 6. Refusal to take medications	Seizure Disorder Poor expressive language skills- primarily non-verbal Low frustration tolerance Difficulty processing Difficulty regulating emotions. ASD Trauma history Sexual abuse history Mistrust of others Separation from mother and family	Has reached "boiling point" Has become too overwhelmed by environment Feelings of sadness or anxiety have become overwhelming Is unable to be distracted Is unable to safely maintain using lesser restrictive measures such as proximity Cannot process what is happening Possible trauma reaction	1. Continue to try interventions mentioned above 2. Continue to manage the environment, give space and keep in LOS. 1. If Youth is harming self or others, the least restrictive pmt intervention may be used.	House Staff Behaviorist Behavioral Associate Clinical Coordinator Medical department Mother DCF worker Charge supervisor Medical dept 911- if needed

CSCPIP

Behaviors/Signs/Symptoms STAGE IV	Biopsychosocial Vulnerabilities	Triggers	Interventions	Persons Involved/Phone #'s
1. Attempts to inflict severe harm to self and/or others without being able to return to baseline 2. Has run off-campus	Seizure Disorder Poor expressive language skills- primarily non-verbal Low frustration tolerance Difficulty processing Difficulty regulating emotions. ASD Trauma history Sexual abuse history Mistrust of others Separation from mother and family	Youth is in crisis and has not responded to interventions. Youth cannot be returned to baseline. Youth is at imminent risk to self and/or others	1. Continue to use verbal prompting/encouragement to return to baseline. 2. Use PMT measures only if unable to safely manage using all other alternatives 1. 911 should be called if Youth has eloped off premises and staff are unable to return to campus	House Staff Behaviorist Behavioral Associate Clinical Coordinator Medical department Mother DCF worker Charge supervisor Medical dept 911- if needed

Involvement of Direct Care Staff

- Front line – important for population change, first hand knowledge – observations of behaviors

Roles come into play: Behaviorists, BA, BL, BTs

Greater Involvement = Greater outcome

Involvement

Empowerment

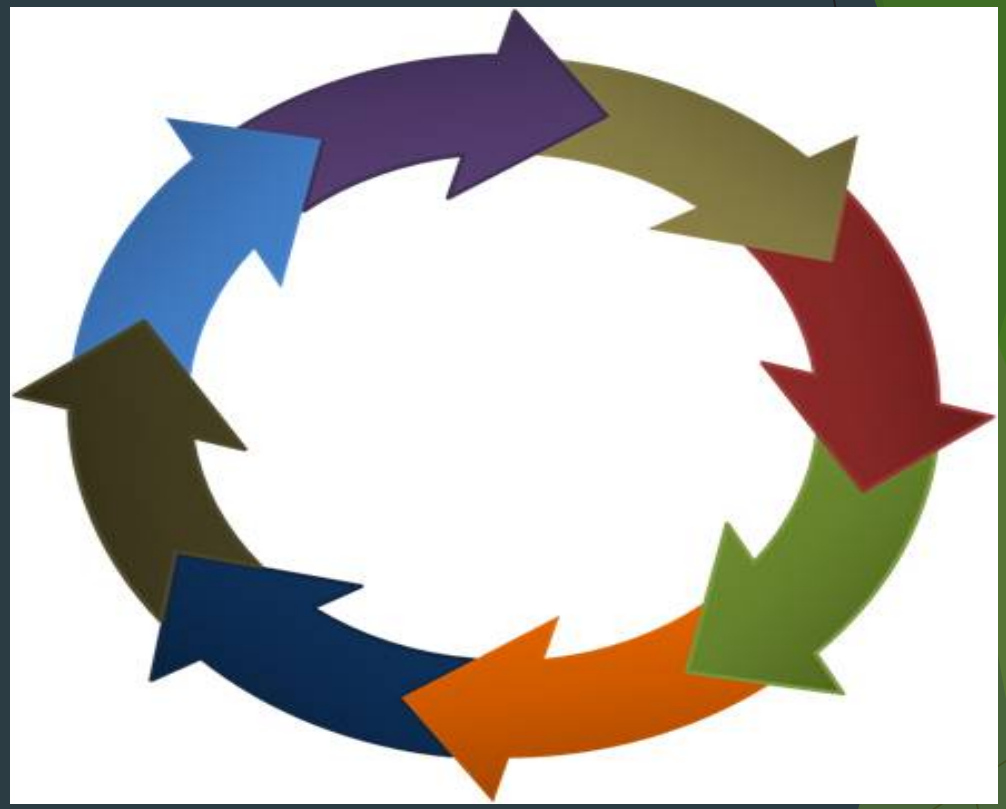
Education/Training

Satisfaction

Understand Client better

Reduced S/R

Better Outcomes



Debriefing

- Another core strategy of S/R reduction
- What is it?
- Why is it important?
- Use of therapeutic rapport
- Importance of using creative and flexible ways to include clients & staff

2 Step Process

Immediate:

Staff Involved

Charge Supervisor

Youth as clinically indicated

Secondary:

Clinical Team, Behaviorists, Staff involved,BA, BL, Admin as Necessary, Medical, OT

Collaboration, forum

Youth as clinically indicated

** Depending on youth's ability to process this is modified**

Systems Impact of Debriefings

- Empowerment & Understanding
  - Staff Involvement
  - Staff Awareness
  - Staff Skills

Debriefing continued

- Clinical coordinator facilitates, explores, supports
- Precursors, Triggers, Actual Event, Intervention
- What did we learn:

  Individual (precursors, triggers, behaviors, med issues)

  System (Environment, Sensory, Family, Staff, Agency)

DATE OF REVIEW: 5/22/15 RE: Youth		SUBMITTED BY: Clinical Coordinator ABUSE/NEGLECT ALLEGATION FILED?: No	
PEOPLE PRESENT AT REVIEW:	**SUMMARY OF THE EVENT:**	**KEY RISK ISSUES:**	**SPECIFIC ACTION POINTS RECOMMENDED:**
Behavior Technician **Behavior Technician** **Behavior Technician** **Clinical Coordinator** **Clinical Supervisor** **Nurse**	Youth had an incident during therapeutic recreational group on 5/21/15. He made it through the first part of group – some attempts at physical aggression towards BTs but they were able to use proximity and redirect him. Towards the end of group he aggressed towards house lead in the form of scratching and grabbing her. BTs attempted to verbally redirect youth and used proximity. However he was not redirectable and continued to escalate. He continued to engage in physical aggression (scratching, grabbing) and self-injurious behaviors (banging his head). Due to being at imminent risk a physical intervention was used for 5 minutes as he was eventually able to calm down. He was redirected to his room to take space with monitoring. Youth was able to do this and was later seen by medical.	Physical aggression towards others and risk of injury to others, Self-injury including banging head and potential risk to self, head trauma.	1. Reduce group time as an hour group is too long for Youth and does better with shorter groups: 20-30 minutes each. 2. Set up expectations for Youth at the start of group – verbally and visually as he does well when he knows what is expected of him. Youth also does well with routine and therefore if there are any changes in this, this should be explained to him as best as possible again pairing verbal with visual strategies. 3. Those working with youth should keep in mind that Youth does not do well with waiting around, waiting for an activity to start or a lack of structure. This should be kept in mind and avoided if possible.
Documentation Reviewed: Critical Incident Report, meeting notes: Critical Incident			

ACTION POINT	RESPONSIBLE PARTY
Reduce group time as an hour group is too long for Youth and does better with shorter groups: 20-30 minutes each.	Group facilitators
Set up expectations for Youth at the start of group – verbally and visually as he does well when he knows what is expected of him. Youth also does well with routine and therefore if there are any changes in this, this should be explained to him as best as possible again pairing verbal with visual strategies.	Group facilitators, Behavior technicians
Those working with youth should keep in mind that Youth does not do well with waiting around, waiting for an activity to start or a lack of structure. This should be kept in mind and avoided if possible.	Group facilitators, Behavior technicians

ACTION POINT RESOLUTION		
ACTION POINT UPDATE	DATE COMPLETED	SIGNED OFF (NAME & SIGNATURE)
Reduce group time as an hour group is too long for Youth and does better with shorter groups: 20-30 minutes each.	5/22/15	Group facilitators, Name
Set up expectations for Youth at the start of group – verbally and visually as he does well when he knows what is expected of him. Youth also does well with routine and therefore if there are any changes in this, this should be explained to him as best as possible again pairing verbal with visual strategies.	5/24/15	Group facilitators, Name, Behavior technicians, Name
Those working with youth should keep in mind that Youth does not do well with waiting around, waiting for an activity to start or a lack of structure. This should be kept in mind and avoided if possible.	5/22/15	Group facilitators, Name, Behavior technicians, Name

The Impact of Debriefing

- Validate and Empower Staff
- Deeper Understanding of the youth and multi-systemic factors (from person to system)
- Modify BSP/CSCPIP: evaluate consistency
- Treatment strategies: medical and clinical
- Environmental modifications
- System changes: involvement, awareness, skills

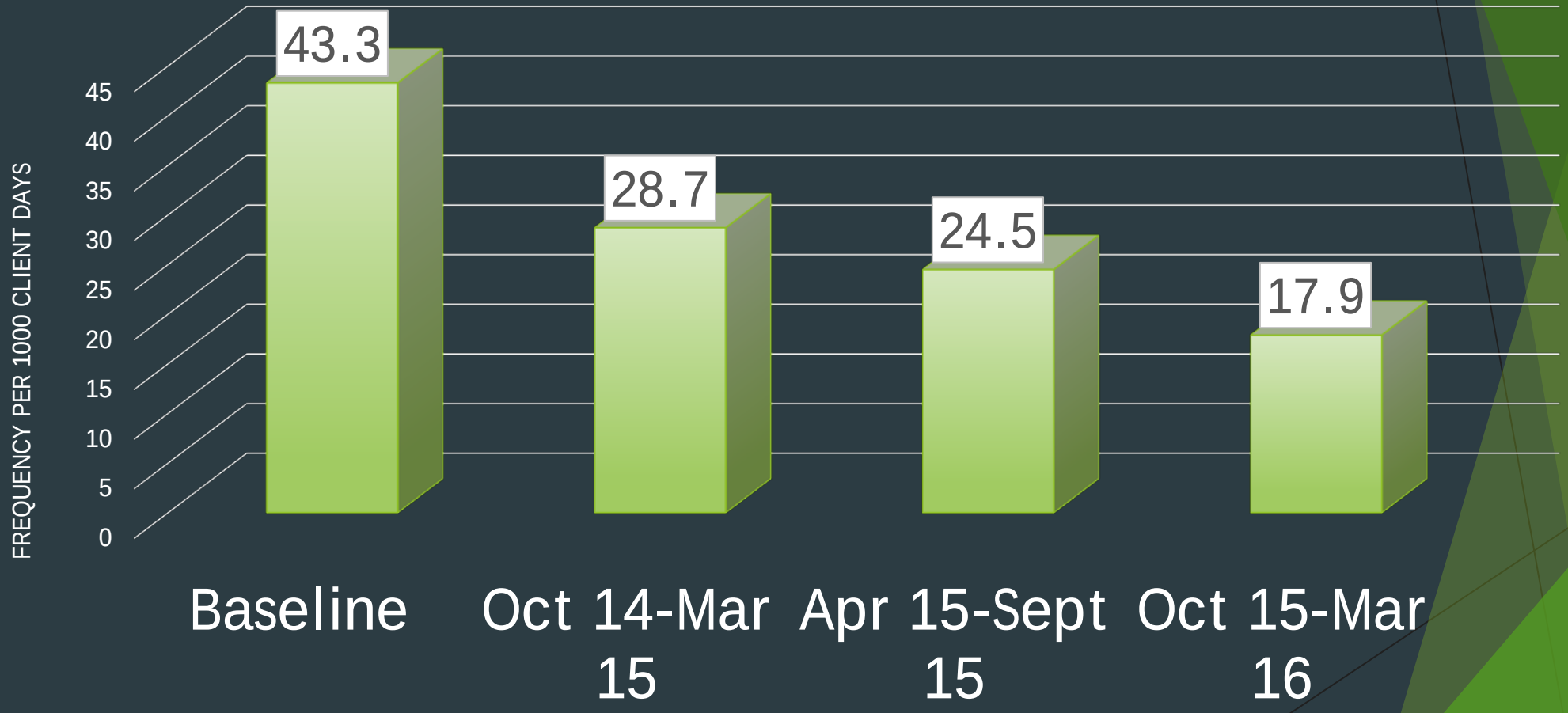
Debriefing Impacts the Cross Systems

- Updated based on findings of debriefing
- Working document
- FRED GOES TO THE DOCTOR…

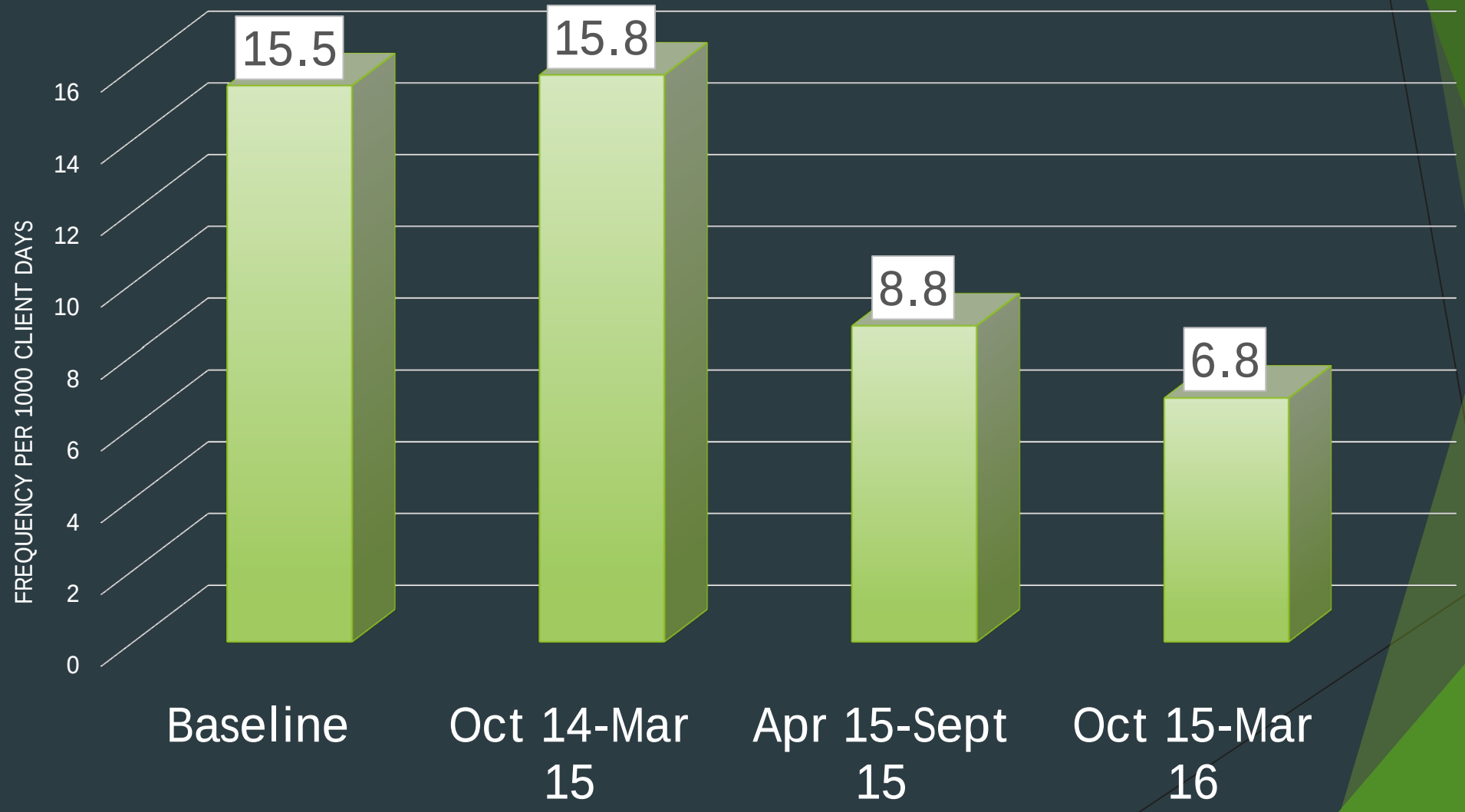
Lets see the numbers!

- Baseline data
- Snapshot of decrease in restraints and seclusions over an 18 month period
- Frequency per 1,000 client days accounting for weekly census changes

Data Adelbrook-Restraints



Data Adelbrook-Seclusion



Limitations

- NOT a research study
- Lots of other variables at play
- Lack of consistent baseline for all homes
- Length of stays across all homes is widely varied

Future Directions and Goals

- Increase consumer roles
- Continue to steadily decrease R&S and evaluate data
- Continue to provide training and empowerment to staff
- Ongoing collaboration with various systems

Questions & Answers

Acknowledgements:

Beasley, J. B. (2007) Cross Systems Crisis Plan Guidelines.

Huckshorn, K.A. National Association of State Mental Health Program Directors (2006) Six Core Strategies for Reducing Seclusion and Restraint Use.