

# Advancing Seclusion and Restraint Prevention Efforts in Texas Residential Treatment Centers

Creating a Culture of Care Initiative Evaluation:  
September 2015

**TNOYS**  
TEXAS NETWORK OF  
YOUTH SERVICES

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## Executive Summary

Researchers estimate that approximately 25 percent of children and adolescents have experienced at least one traumatic event during their lifetime, including life-threatening accidents, disasters, maltreatment, assault, and family and community violence. Despite children's resiliency, repeated exposure to trauma can change their psychobiological development and increase factors associated with poor outcomes. Research demonstrates that high-risk behaviors, low academic performance, and difficulty with peer and family relationships are potential consequences of repeated exposure to trauma.

Children in state child welfare systems, especially foster care; have a higher prevalence of mental health problems than the general population, according to multiple researchers. They are also more likely than other children to have experienced trauma. Clinicians are learning that certain interventions, like seclusions and restraint, in foster care and other residential settings may add to the traumatization of children and youth who already have trouble coping with their past experiences.

Over the past decade the use of seclusion and restraint interventions has come under intense scrutiny as researchers, clinicians, and stakeholders have identified physical and psychological risks – including death, disabling physical injuries, and significant trauma when using these interventions. As a result, many effective and inexpensive alternatives to seclusion and restraint use have been developed.

The U.S. Health and Human Services Department endorses The Six Core Strategies as an effective and evidence-based practice to reduce seclusion and restraint practices in multiple mental health settings. The Six Core Strategies to Reduce the Use of Seclusion and Restraint<sup>®</sup> consist of the following: (1) organizational leadership, (2) use of data, (3) staff development, (4) use of restraint/seclusion prevention tools, (5) opportunities for youth, family, and advocates' input into service delivery, and (6) use of debriefing practices.

The Creating a Culture of Care initiative was a collaboration between the University of Texas' Hogg Foundation for Mental Health and Texas Network of Youth Services to make a dramatic impact on how youth in Texas residential treatment centers receive care. The purpose of the initiative was to implement the Six Core Strategies to Reduce the Use of Seclusion and Restraint<sup>®</sup> at residential treatment centers that serve youth with mental health and behavioral needs. Texas Network of Youth Services provided training, technical assistance, and other support to residential treatment centers throughout the initiative.

Texas Network of Youth Services received a three-year grant from the University of Texas Hogg Foundation for Mental Health to implement the Creating a Culture of Care initiative. Over the grant period, 11 residential treatment centers participated in the initiative and received training and technical assistance services to support and strengthen their efforts to implement the Six Core Strategies framework. In this report, these residential treatment centers are referred to as "intensive sites." Non-intensive sites included all other licensed residential treatment centers that were not accepted into the CCC initiative and did not receive the intensive training and support services. The project was funded from September 2011 to August 2014.

## Key Findings

To evaluate the Creating a Culture of Care initiative, quantitative and qualitative research methods were used to measure seclusion and restraint reporting and document organizational changes, respectively, at 11 intensive sites. The following key findings are discussed in the report:

- Administrative and direct care staff from intensive sites that achieved a reduction in the number of restraints identified which of the Six Core Strategies they believed were integral to their success:
  - Engaged and supportive leadership (Strategy 1)
  - Incorporating data into their prevention efforts (Strategy 2)
  - Workforce training about preventing seclusion/restraint use (Strategy 3)
  - Individualized treatment approaches (Strategy 4)
- Regardless of their achievement in reducing seclusions and restraints, the leadership and direct care staff at intensive site residential treatment centers identified the following lessons from the Creating a Culture of Care initiative:
  - Engaged and supportive leadership is critical to successful implementation of the Six Core Strategies.
  - Incorporating data collection and analysis in seclusion and restraint prevention efforts aids restraint reduction.
  - Debriefing activities contribute important data to assist prevention efforts.
  - Open communication among staff improves data collection and strengthens prevention efforts.
  - Training helps workers feel supported and focus on youths'/clients' needs.
  - Flexible and individualized treatment approaches to youth yields results.
  - Staff plays a vital role in successful organizational change.
- Intensive sites achieved greater reductions in restraints than non-intensive sites. From 2011 to 2013, an overall 25 percent reduction occurred in the number of restraints reported by intensive sites, while collectively non-intensive sites reported an 11 percent reduction for the same period of time.
- Seclusion as an intervention is rarely used by most residential treatment centers participating in the Creating a Culture of Care initiative. Only one intensive site reported using seclusions and their progress to reduce use of seclusion varied each year of the initiative.
- Individually, intensive sites varied in their ability to reduce restraints while participating in the Creating a Culture of Care initiative.
- Between 2011 and 2012 intensive sites reported reductions in restraints ranging from 34 percent to almost 100 percent.
- One intensive site joined the Creating a Culture of Care initiative soon after it was established. To date, this site has remained restraint free.

- Between 2012 and 2013 intensive sites reported reductions in restraints ranging from 4 percent to 100 percent.
- In 2011 participating intensive sites accounted for almost half of all reported restraints in Texas residential treatment centers; or 46 percent. In 2012 and 2013, the proportion abated slightly to 44 percent and 42 percent, respectively.
- Intensive sites that did not report success in implementing the Six Core Strategies reported having difficulty providing youth with one-on-one time with staff.
- Evaluating residential treatment center staff about their competencies in trauma-informed care practices provides continuous information about performance and opportunities for skill development.
- Individualized training and networking were the most useful forms of support that Texas Network of Youth Services staff provided to intensive site residential treatment centers.
- Discretionary grant funds proved useful to intensive sites in furthering their implementation of the Six Core Strategies. The funds provided support for residential treatment centers to create calming rooms, purchase weighted blankets, and receive additional training.

In conclusion, the Creating a Culture of Care initiative serves as evidence to state regulators and policymakers that organizational culture change to reduce seclusion/restraint use at residential treatment centers can occur successfully. This evidence is noteworthy because it demonstrates that traditional obstacles, such as regulations and funding limitations, are not preventing the immediate implementation of evidence-based practices to reduce seclusion and restraint use in all Texas residential treatment centers. Reducing use of seclusion and restraint practices in Texas residential treatment centers is possible through the supported implementation of the Six Core Strategies.

# Introduction

## Seclusion and Restraint Use Background Information

Various healthcare and residential treatment settings use seclusion and restraint interventions. Consequently, persons of any age may be affected by their use. Seclusions and restraints (S/R) are intended for use when consumers who are receiving treatment demonstrate behavior that might cause self-harm or harm to others. The Centers for Medicaid and Medicare Services (CMS) define physical restraint as “any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident’s body that the individual cannot remove easily that restricts freedom of movement or normal access to one’s body.”<sup>1</sup> CMS defines seclusion “as the involuntary confinement of a person in a room where they are physically prevented from leaving for any period of time.”<sup>2</sup>

Regardless of the healthcare or treatment setting, maintaining the safety of staff and consumers is a priority. At present, the purpose of S/R use is to limit a person’s movements to prevent imminent self-harm or harm to others; however this was not always the case. To date, S/R interventions are used inconsistently and sometimes inappropriately in multiple settings. Their utility has been called into question, specifically when used with children and adolescents. Busch and Shore identified that there was little agreement regarding the clinical value and benefits of seclusion and restraints for certain populations.<sup>3</sup>

Reporting the frequency and rationale for S/R usage has been inconsistent and varied among settings. Consequently, due to the wide variability of methodologies in reporting their usage, tracking and comparing their usage across settings and populations has produced inconclusive results. To ensure that S/R are used appropriately to prevent the escalation of violence, state and federal legislation was enacted to ensure patients’ safety and reduce inappropriate use of S/R in healthcare and treatment settings.

### *Trauma and its Influence on Seclusion and Restraint Use*

Multiple factors may influence a person to demonstrate behavior that might cause self-harm or harm to others. Understanding these factors may result in reducing S/R use. One factor, trauma and its effect on human behavior, is an area researchers are studying. Researchers estimate that approximately 25 percent of children and adolescents will have experienced at least one traumatic event during their lifetime, including life-threatening accidents, disasters, maltreatment, assault, and family and community violence.<sup>4</sup> Additionally, according to Finklehor et al., more than 60 percent of the children surveyed in 2008 were exposed to violence within the past year, either directly or indirectly (i.e., as a witness to a violent act; by learning of a violent act against a family member, neighbor, or close friend; or from a threat against their home or school).<sup>5</sup> Despite children’s resiliency,

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<sup>1</sup> Knox, D., and Holloman, G., Use and Avoidance of Seclusion and Restraint: Consensus Statement of the American Association for Emergency Psychiatry Project BETA Seclusion and Restraint Workgroup. *West Journal of Emergency Medicine*, Vol. 13 (1), February 2012, 35-40.

<sup>2</sup> Ibid.

<sup>3</sup> Busch, A. and Shore, M., Seclusion and Restraint: A Review of Recent Literature. *Harvard Review Psychiatry*, Volume 8, Number 5, November 2000, 261-270.

<sup>4</sup> Adolescent Traumatic Stress and Substance Abuse Treatment Center, Fact Sheet Series for Clinicians treating teens with Emotional & Substance Use Problems, retrieved from Internet on April 12, 2015.

<sup>5</sup> U.S. Department of Justice Office of Juvenile Justice and Delinquency Prevention, Retrieved on June 17, 2015 from <https://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf>

repeated exposure to trauma and violence can change their psychobiological development and increase factors associated with poor outcomes.<sup>6</sup>

Child abuse and neglect, violence, and exposure to parental substance abuse are examples of the types of trauma prevalent among children and families in state child welfare systems.<sup>7</sup> Identifying trauma exposure and studying its role in the behavioral and psychological disorders of children is now imperative.<sup>8</sup> Clinicians are learning that children with exposure to multiple traumatic events may be overtly or covertly re-traumatized in the foster care system.<sup>9</sup> When combined with exposure to certain discipline interventions in foster care settings, these children, who already have trouble coping with their past experiences, may continue to be traumatized.<sup>10</sup> Research demonstrates that high-risk behaviors, low academic performance, and difficulty with peer and family relationships are potential consequences of repeated exposure to trauma.<sup>11</sup>

Recognizing that exposure to traumatic experiences influences human behavior has led to research about new models of treatment that take into account that treatment environments may be covertly and/or overtly traumatizing too.<sup>12</sup> The purpose of these models, known as trauma-informed care (TIC), is to inform and train mental health professionals and staff about trauma and its effects. In other words, trauma-informed care focuses on avoiding re-traumatizing children and youth while they are receiving mental health assistance.<sup>13</sup>

### *Seclusion/Restraint Reduction Efforts*

Seclusion and restraint practices have multiple negative effects that not only affect the youth subjected to them, but also staff.<sup>14</sup> Staff may incur injuries. Additionally, S/R use is costly to agencies in terms of program operations. It lowers staff morale and S/R interventions are inconsistent with researched best practices.<sup>15</sup> Reducing the use of S/R interventions improves the safety of consumers who are receiving treatment and staff. It also leads to fewer staff and consumer injuries, as well as deaths.

Federal government research shows that children are subjected to S/R interventions at higher rates than adults.<sup>16</sup> Children and youth are at more risk for injury during S/R

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<sup>6</sup> Ko, S, Kassam-Adams N., Wilson C., Ford J., et. al Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice. *Professional Psychology: Research and Practice*, vol. 39, No. 4, 2008, 396-404.

<sup>7</sup> Hummer, V.et. al, Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A curriculum for organizational change. *Child Welfare*, vol. 89, No. 2, 2010, 79-85.

<sup>8</sup> Ibid.

<sup>9</sup> Hummer, V.et. al, Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A curriculum for organizational change. *Child Welfare*, vol. 89, No. 2, 2010, 79-85.

<sup>10</sup> Ibid

<sup>11</sup> Ko, S, Kassam-Adams N., Wilson C., Ford J., et. al Creating Trauma-Informed Systems: Child Welfare, Education, First Responders, Health Care, Juvenile Justice. *Professional Psychology: Research and Practice*, vol. 39, No. 4, 2008, 396-404.

<sup>12</sup> Hummer, V.et. al, Innovations in Implementation of Trauma-Informed Care Practices in Youth Residential Treatment: A curriculum for organizational change. *Child Welfare*, vol. 89, No. 2, 2010, 79-85.

<sup>13</sup> Ibid

<sup>14</sup> Huckshorn, K., Redesigning State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 33, No. 4, July 2006, 482-491.

<sup>15</sup> LaBel, J., Huckshorn, K., and Caldwell, B., Restraint Use in Residential Programs: Why Are Best Practices Ignored?. *Child Welfare*, Volume, 89, No. 2, 2010,169-189.

<sup>16</sup> GAO, Extent of Risk from Improper Restraint or Harm is Unknown, Testimony before the Committee on Finance, U.S. Senate. (GAO/T-HEHS-00-026) October 26, 1999, 1-16

interventions because they are smaller and weaker than adults.<sup>17</sup> Staff may unintentionally use too much force or apply too much pressure during a restraint, which may lead to injury or even death.

In 1998, the *Hartford Courant* newspaper series exposed injuries and deaths related to S/R and brought national attention to this issue. Soon thereafter the Medical Director's Council of the National Association of State Mental Health Program Directors (NASMHPD) researched and concluded that the use of seclusion and restraint was a "treatment failure."<sup>18</sup>

In 2000 to address some of these concerns, the U.S. Congress enacted the Children's Health Act. It established national standards about the use of S/R in all public and private health care facilities that receive federal funding.<sup>19</sup> The results of the legislation and subsequent legislative hearings led to more government attention about the S/R use and clarified definitions, reporting requirements, and other issues.<sup>20</sup> Despite the passage of the legislation more than a decade ago, provisions of it still await rule promulgation.<sup>21</sup> Without established regulations, the S/R policies contained in the Children's Health Act cannot be fully implemented.

In 2001, national organizations including the U.S. Health and Human Services Department Substance Abuse and Mental Health Services Administration (SAMHSA), NASMHPD, and other organization started prevention programs to reduce the use of S/R interventions.<sup>22</sup> Between 2001 and 2009, SAMHSA funded several efforts<sup>23</sup>:

- Developed the Six Core Strategies to Reduce the Use of Seclusion and Restraint<sup>®</sup> training curriculum;
- Provided training programs to groups of leadership staff from residential and hospital programs in nearly all 50 states;
- Developed a rigorous evaluation tool and technical assistance to residential and hospital programs using this tool;  
Conducted two large-scale evaluations in eight states and multiple residential and hospital programs; and
- Created an "Alternatives to Seclusion and Restraint Recognition Program" with data and information from hospitals and residential centers' about their outcomes.

Because of the attention given to the prevention of S/R use in mental health settings, attention turned to how S/R was used in child welfare, juvenile justice, and educational settings. New trainings and interventions for children and youth have been developed and

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<sup>17</sup> Ibid.

<sup>18</sup> Child Welfare League of America. Retrieved from Internet on April 10, 2015 from: <http://www.cwla.org/reducing-restraint-and-seclusion/>

<sup>19</sup> Huckshorn, K., Redesigning State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 33, No. 4, July 2006, 482-491.

<sup>20</sup> Ibid.

<sup>21</sup> A. Hayes (personal communication, July 23, 2015 and August 21, 2015)

<sup>22</sup> Huckshorn, K., Redesigning State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 33, No. 4, July 2006, 482-491.

<sup>23</sup> Huckshorn, K., Redesigning State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 33, No. 4, July 2006, 482-491. and Child Welfare League of America. Retrieved from Internet on April 10, 2015 from: <http://www.cwla.org/reducing-restraint-and-seclusion/>

are designed to limit S/R use, reduce opportunities for re-traumatization, and promote trauma recovery.<sup>24</sup>

### *Six Core Strategies Identified to Reduce the Use of Seclusion and Restraint*

The Six Core Strategies to Reduce the Use of Seclusion and Restraint<sup>®</sup> (6CS) is an evidence-based framework that when implemented demonstrates decreased use of S/R incidents in certain settings.<sup>25</sup> Specifically, the 6CS facilitate organizational change and how care is provided in treatment settings. It focuses on the prevention of conflict and violence, the reduction in S/R use, the implementation of trauma-informed care principles, and the inclusion of the consumer in his or her care.

Spurred by high profile investigative journalism reports about deadly results from the use of S/R, a 1999 Government Accountability Office report<sup>26</sup> that identified the risks about the improper use of S/R, and growing concerns by stakeholders' led the National Association of State Mental Health Program Directors to bring together experts from entities that had implemented successful strategies to reduce S/R use.<sup>27</sup> It was during this collaboration that common strategies emerged to reducing S/R use and eventually six were identified.<sup>28</sup> Figure 1 shows the Six Core Strategies to Reduce the Use of Seclusion and Restraint<sup>®</sup>.

**Figure 1: Six Core Strategies to Reduce the Use of Seclusion and Restraint**<sup>29</sup>

1. Leadership in Organizational Change
2. Using Data to Inform Practice and Monitor Change
3. Workforce Development
- 4a. Use of Prevention Tools /Risks; Identifying and Managing Conflict/Violence Risk Factors
- 4b. Use of Trauma Sensitive Treatment Services
5. Inclusion of Consumer/Youth, Family, Advocacy Roles in Care Setting
6. Debriefing- After Intervention

SAMHSA endorsed the 6CS as an effective and evidence-based practice. In January 2003, seven states implemented the 6CS. Since then, the 6CS framework has been used in nearly 1,000 state, private hospitals, and agencies in more than half the states and the District of Columbia.<sup>30</sup> The 6CS have been adopted outside the U.S. in Australia, Canada, and Finland.<sup>31</sup> More information about the 6CS can be found on SAMHSA's registry of evidence-based practices: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=278>.

<sup>24</sup> Huckshorn, K., Redesigning State Mental Health Policy to Prevent the Use of Seclusion and Restraint. *Administration and Policy in Mental Health and Mental Health Services Research*, Vol. 33, No. 4, July 2006, 482-491.

<sup>25</sup> Preventing Violence and the Use of Seclusion and Restraint: An Expert Interview With Kevin Huckshorn. Retrieved from Medscape Medical news on April 3, 2015 from: <http://www.medscape.com/viewarticle/711633>

<sup>26</sup> Ibid.

<sup>27</sup> Ibid.

<sup>28</sup> Ibid.

<sup>29</sup> Huckshorn, K. National Association of State Mental Health Program Directors. Trauma Informed Care (TIC) Planning Guidelines for use in Developing an Organizational Action Plan, 2009.

<sup>30</sup> National Registry of Evidence-based Programs and Practices. Retrieved from Internet on March 16, 2015 from: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=278>

<sup>31</sup> National Registry of Evidence-based Programs and Practices. Retrieved from Internet on March 16, 2015 from: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=278>

### *Factors Influencing the Implementation of The Six Core Strategies®*

Despite knowing what strategies lead to an environment that reduces S/R use, organizations need a champion to ensure a change is adopted. As identified by Currie, “Policy changes are necessary but not sufficient to eliminate the use of seclusion and restraint. Success begins with a change in culture, from one of power to one of empowerment, from coercion to caring, and from hopelessness to hope.”<sup>32</sup> As with other organizational culture change movements, Currie also cites the importance of leadership. “Leadership at the top is essential... these changes can’t be implemented by fiat—the buy-in of key staff is essential.”<sup>33</sup>

In addition to the support of leadership, researchers identified other elements necessary for a shift in organizational culture to occur about S/R use. These include:

- An adequate number of qualified staff to meet youth treatment needs.
- Staff training; especially in verbal crisis management, de-escalation techniques, active treatment, active risk assessment, and risk-based treatment planning.
- An availability and use of appropriate antipsychotic medications.
- An environment of care that promotes patient comfort, dignity, privacy, and personal choice.
- State-level, aggregate data about each facility’s incidents of seclusion and restraint that can be used to inform management and quality improvement activities.<sup>34</sup>

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<sup>32</sup> Currie, C., SAMHSA’s Commitment to Eliminating the Use of Seclusion and Restraint. *Psychiatric Services*, 2005, Vol. 56, No. 9, 1139-1140.

<sup>33</sup> Ibid.

<sup>34</sup> Ibid.

## Creating a Culture of Care Initiative

In 2011, Texas Network of Youth Services (TNOYS) received a three-year grant from the University of Texas Hogg Foundation for Mental Health to pilot the Creating a Culture of Care (CCC) initiative. The purpose of the CCC initiative was to provide intensive support services to a group of selected residential treatment centers (RTC) to facilitate organizational culture change to reduce their use of S/R practices. The selected RTCs received training to implement the Six Core Strategies to Reduce the Use of Seclusion and Restraint<sup>®</sup> framework. The opportunity to participate in the initiative was limited to RTCs licensed by the Texas Department of Family and Protective Services (DFPS) to serve youth with mental health and behavioral challenges. Throughout the initiative RTCs that participated received training from national and local experts as well as ongoing technical assistance and support to ensure their continued progress. The project was funded from September 2011 to August 2014 with an additional year of funding approved to complete the evaluation.

Continuing in its commitment to reduce seclusion and restraint use in Texas and maximize its efforts, the Hogg Foundation focused solely on RTCs because the juvenile justice, foster care, or psychiatric hospital systems referred most RTC residents. Research suggests that many of these youth have histories of abuse or trauma, and that restraining or secluding a youth who has a history of trauma-related behavior is likely to re-traumatize the youth and may as a result intensify the problematic behavior.

Beginning in September 2011, TNOYS contacted all DFPS-licensed RTCs in Texas and offered them the opportunity to attend specialized training by national and local experts. Twenty-eight RTCs (42%) took advantage of one or more training opportunities during the CCC initiative. These included initial trainings to kick off the initiative in 2012, regional trainings in 2013, and a follow-up training by national experts in 2013.

In January of 2012, two training seminars featuring: Beth Caldwell, MS; Janice LeBel, Ph.D.; and Kevin Ann Huckshorn, RN, MSN, CAP, ICADC, were held in Houston and Austin. These seminars included information on the 6CS framework; the Building Bridges Initiative to engage youth and families in treatment; neurobiological and psychological effects of trauma; and debriefing and action planning for agency culture change. TNOYS learned about the Building Bridges Initiative when first consulting with Beth Caldwell to plan the January 2012 training seminars. It was clear that Building Bridges offered training content that was a complement to the 6CS framework and further emphasized best practices in family-driven and youth-guided care. Throughout the CCC initiative, participating RTCs used Building Bridges self-assessment tools and had the option of further consultation with Beth Caldwell for support if they had youth and family engagement as part of their action plans.

At the seminars, teams of 1 to 10 staff members from participating RTCs attended and discussed how to dramatically reduce S/R use at their facilities. Participants had the opportunity to brainstorm with experts and each other, as well as to create action plans and goals for the upcoming year.

Following these initial trainings TNOYS developed an application process to select a limited number of RTCs to receive ongoing individualized support. The application process required several prerequisites to be met and for facilities to agree to fulfill certain

responsibilities. Selected RTCs had to demonstrate: leadership buy-in to the initiative, openness to change, and include the involvement of current and former residents as well as family members, when possible.

Eleven RTCs participated in the CCC initiative. Nine organizations were originally selected, however two organizations dropped out of the initiative in the first year and another was sold to new owners. The RTC that was sold re-joined the initiative in 2013 under new leadership, Children's Hope. Children's Hope RTCs are identified as three separate facilities because each are in different geographic locations and licensed as separate facilities under one company. Two more facilities joined the initiative: one in 2013 and another in 2014 that had staff in attendance at the kick-off training in 2012.

The intensive site RTCs received technical assistance and support and agreed to:

- Identify a facility leadership team to participate in the project.
- Select a coordinator: ideally a senior manager, to function as the team's leader and contact person. The selected person should be chosen on the consent and endorsement of all leadership team members.
- Develop a preliminary action plan using the knowledge gained from completing the *Building Bridges* assessment tool and reviewing the 6CS.
- Participate in ongoing training and technical assistance opportunities as well as follow-up evaluation surveys and activities conducted by TNOYS.

With the exception of a small amount of discretionary funds (less than \$1,000 per RTC) that became available later in the project, the intensive site RTCs did not receive any other grant funding for their participation in the CCC initiative.

Throughout the CCC initiative TNOYS staff provided diverse opportunities to support the RTCs' staff in their efforts to reduce S/R use. TNOYS staff individualized their support to meet the needs expressed by each RTC, including the following:

- Organizing group and site-specific technical assistance and trainings.
- Facilitating networking events and providing travel funds for direct care staff and leadership to attend.
- Facilitating conference calls on RTC-identified topics.
- Providing resource materials online and through a CCC initiative discussion board (Groupsite).
- Distributing newsletters and other communication materials about trauma-informed care and S/R topics.
- Providing individualized technical assistance through calls, emails, and site visits.
- Distributing discretionary funds for travel to conferences, RTC-specific training events, and for use toward comfort/calming room and staff development supplies at RTCs.

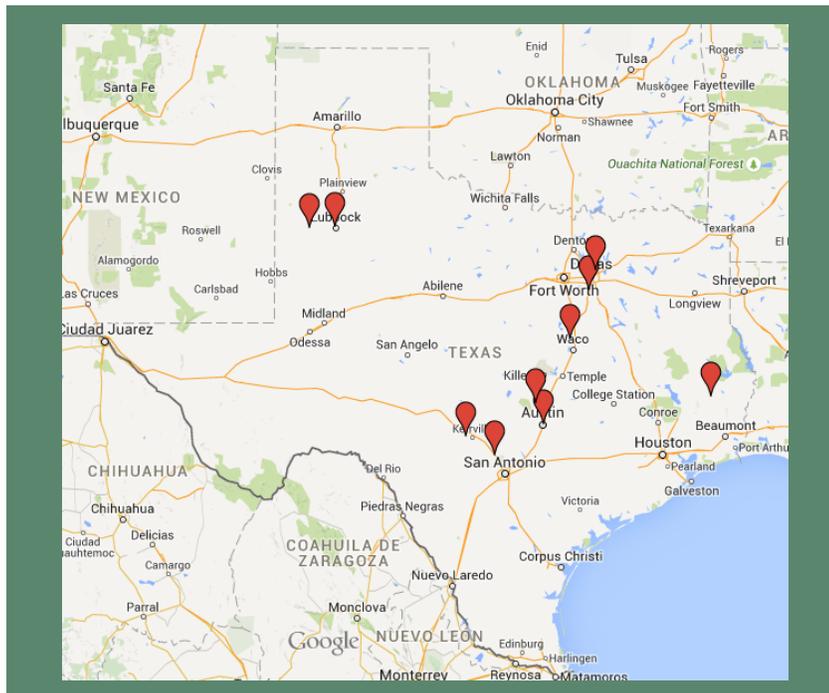
Figure 2 shows the locations of the 11 intensive RTC sites that contributed data to this project. It does not include additional RTCs that left the initiative prior to its completion.

The sites are:

1. Athletes For Change, Glenn Heights, TX; maximum capacity – 27 youth
2. Autism Treatment Center, Dallas, TX; maximum capacity - 31 youth

3. Brookhaven Youth Ranch, West, TX; maximum capacity - 71 youth
4. Children's Hope (West), Levelland, TX; maximum capacity - 48 youth
5. Children's Hope (Washington), Levelland TX; maximum capacity - 20 youth
6. Children's Hope, Lubbock, TX; maximum capacity - 40 youth
7. Hill Country Youth Ranch, Ingram, TX; maximum capacity - 50 youth
8. Helping Hand Home for Children, Austin, TX; maximum capacity - 41 youth
9. Meridell Achievement Center, Liberty Hill, TX; maximum capacity - 134 youth
10. Roy Maas Youth Alternatives Meadowland Campus, Boerne, TX; maximum capacity - 48 youth
11. Sinclair Children's Center, Woodville, TX; maximum capacity - 35 youth

**Figure 2: Locations of the Intensive Site Residential Treatment Centers, 2015**



In year two of the CCC initiative, TNOYS continued to visit each of the RTC intensive sites at least twice to assess progress and update action plans. The sites continued to receive communication via email and telephone during this time period as well as individualized trainings and technical assistance. TNOYS staff and RTC staff teams brainstormed together to solve everyday challenges as well as share progress and resources. TNOYS staff also facilitated cross-site communication through conference calls, networking meetings, and site-to-site mentorships.

In August 2012, TNOYS held its 30<sup>th</sup> annual statewide conference and provided scholarships to all intensive RTC sites to attend. Six intensive RTC sites sent staff to network and learn about best practices and creative solutions related to their work with youth. The conference included programming specifically targeted toward RTCs, including a networking reception, as well as a panel discussion about the CCC initiative moderated by TNOYS staff and presented by representatives from three intensive RTC sites. In December 2012, TNOYS hosted a regional meeting in Austin for all intensive RTC sites for consultation and networking as well as to assess progress and needs to date.

Based on feedback from RTCs after the first year of the grant, TNOYS coordinated a one-day workshop and offered it to all RTCs in the state in three locations (Austin, Houston, and Dallas-area) between November 2012 and May 2013 to strengthen the work of existing CCC initiative participants and to recruit new RTCs for participation.

The topics addressed during the trainings included an introduction to the 6CS (presented by Jack Nowicki, LCSW), adolescent brain development (presented by Meera Beharry, MD), and self-care to avoid burnout for RTC staff (presented by Nora Drueppel, LCSW). Additionally, TNOYS staff provided technical assistance in the second year of the grant that included: focusing on positive change, identifying youth triggers to problem behaviors, and leadership/supervision; and teamwork.

Several new RTCs expressed interest in joining the CCC initiative as a result of these trainings, and one successfully completed the application process. Two additional RTCs joined the CCC initiative later that year. One of the RTCs, Children's Hope, included three RTC campuses operating in separate locations in west Texas.

In August 2013, at the end of the second year of the grant, TNOYS also coordinated a full-day institute as part of its 31<sup>st</sup> annual conference. All intensive RTC sites were offered scholarship opportunities for staff to attend; staff from other types of youth residential programs (e.g., shelters and non-intensive RTCs) was also invited. The institute featured the return of two national experts: Beth Caldwell, MS and Kevin Ann Huckshorn, RN, MSN, CAP, ICADC as well as presentations by staff from three intensive RTC sites and a panel discussion that included youth and caregivers. Staff from two intensive RTC sites also presented a workshop later in the conference week moderated by Dr. Lynda Frost of the Hogg Foundation. It focused on early successes of the CCC initiative and its impact on program development and youth treatment approaches.

Throughout the third year of the grant, TNOYS staff continued to provide ongoing consultation and technical assistance to all 11 intensive RTC sites. Depending on the level of engagement and interest from each site, TNOYS staff visited sites 2 to 3 times a year to discuss progress and update action plans. TNOYS also hosted webinars, conference calls, and training opportunities. TNOYS staff hosted a second regional meeting at Brookhaven Youth Ranch in West, Texas to support consultation between RTC staff and discuss the group's evolving progress and needs.

A major focus during year three centered on completing evaluation activities, in addition to regular training/technical assistance support. TNOYS teams visited each intensive RTC site during the summer of 2014 to administer an adapted *Inventory of Seclusion and Restraint Reduction Inventory (ISRR)* to administrators. Administrators also received an electronic training and technical assistance survey. TNOYS evaluation staff also coordinated and conducted focus groups with direct care staff from each site. TNOYS received approval from the Hogg Foundation to continue training and technical assistance until December 2014 and complete evaluation activities by August 2015.

In May 2015, the TNOYS team invited staff from all intensive RTC sites to a 2-day retreat in Austin to review evaluation results as well as reflect back on their efforts to reduce S/R during the CCC initiative and identify lessons learned and strategies for sustainability. Direct

care staff and administrators from six intensive RTC sites attended as well as representatives from TNOYS and the Hogg Foundation.

## Evaluation Approach

### Description of Evaluation Methods and Tools

To evaluate the CCC initiative, TNOYS used a mixed-methods approach that included surveys with RTC administrators, interviews/focus groups with direct care staff and a statistical evaluation of aggregate data provided by DFPS. Figure 3 shows a timeline of major activities that occurred during the CCC initiative.

**Figure 3: Timeline of Major Trainings and Evaluation Activities**

1. Initial National Experts Training & Action Planning Retreats	1. Individualized T & TA Continues	1. Individualized T & TA Continues
2. Initial Group of Intensive Sites Join	2. Regional Trainings	2. T & TA Survey Distributed
3. Individualized T & TA Begins	3. 2 <sup>nd</sup> Group of Intensive Sites Join	3. EBI Data Received
4. Regional RTC Meeting	4. Regional RTC Meeting	4. ISSRI Survey and Focus Groups Conducted
		5. Follow-up Training by National Experts
2011	2012	2013
<b>CCC Begins</b>		
		2014
		2015
		<b>Evaluation</b>

This evaluation’s objective is to answer the following four research questions as shown in Figure 4.

**Figure 4: Creating a Culture of Care Initiative Research Questions and Data Sources, 2015**

Research Question	Data Source
1. What success was achieved in reducing seclusions and restraints?	Emergency Behavioral Intervention data from Texas Department of Family and Protective Services
2. What contributed to making the Six Core Strategies easier or challenging to implement at a residential treatment center?	ISSRI (6CS Survey) and Focus Groups
3. How was the implementation of the Six Core Strategies achieved?	ISSRI (6CS Survey) and Focus Groups
4. What practices of training and technical assistance are preferred by residential treatment staff to assist with the implementation of Six Core Strategies?	Training and Technical Assistance Survey

In the evaluation design, all Texas licensed RTCs in operation from 2011 to 2014 were assigned to either the intensive site or non-intensive site group. Intensive sites included the 11 licensed RTCs that applied and were accepted into the CCC initiative. They received training in the 6CS framework, in addition to other group and individualized training, and technical assistance from TNOYS staff. Non-intensive sites included all other licensed RTCs that were not accepted into the CCC initiative. They did not receive individualized training and technical assistance from TNOYS staff and they may or may not have received some training in the 6CS or other seclusion and restraint reduction methods.

This evaluation used three sets of data. First, TNOYS requested data reported by RTCs to DFPS for the number of emergency behavioral interventions (EBI). EBI data are counts of the number of restraints, seclusions, and emergency medication interventions used at Texas RTCs and other licensed residential childcare facilities. The state requires RTCs to self-report EBI data to DFPS. This data is reported quarterly and is publically available by

making an open records request. For this evaluation, TNOYS staff requested EBI data for each quarter from 2011 to 2014; however only data from 2011 through the first two quarters of 2014 were made available.

TNOYS used the EBI data as a quantitative indicator of the number of S/R interventions each participating RTC (In this section called “intensive RTC sites”) had during the CCC initiative. The number of S/R reported identified changes over time that may be related to the implementation of the 6CS framework. TNOYS staff conducted analysis of the number of S/R reported by intensive and non-intensive sites to identify any differences or trends that occurred after intensive sites received training about the 6CS and throughout the duration of the CCC initiative.

The second set of data collected from intensive sites was from a completed survey from RTC administrators or managers. These staff completed a modified version of the Human Services Research Institute’s (HSRI) *Inventory of Seclusion and Restraint Reduction Inventory (ISRR)*, hereafter referenced as the 6CS Survey. The purpose of the survey was to determine which components of the 6CS were implemented at each intensive RTC site. It was used for previous studies of the 6CS. For this evaluation, the survey was adapted by TNOYS (with permission) to best capture how the CCC initiative affects RTCs, the target population. The adapted format of the survey was conducive to in-person completion with TNOYS staff rather than participants completing the survey independently and submitting them by mail. HSRI staff also recommended the use of this format. Up to three administrative staff per intensive RTC site were provided the survey and at least one representative from each site completed it. A total 26 administrators and/or managers attended the 6CS leadership meetings where the 6CS survey was administered.

The third set of data consisted of focus group interviews with selected direct care staff from each of the intensive RTC sites. The purpose of the focus group interviews was to identify evidence of organizational culture change occurring at each site after they implemented the 6CS. Sixty-one staff from the 10 intensive RTC sites participated in the focus groups. The average size of each group was 6 people and group sizes ranged from 2 to 12 participants.

Additionally, online surveys were conducted about the training and technical assistance TNOYS staff provided to intensive RTCs. The surveys were sent via email to administrators and supervisors at RTCs who had received training and technical assistance. The purpose of these surveys was to determine which training and technical assistance practices were the most effective for promoting and motivating implementation of the 6CS.

Due to the staggered entry of RTCs into the initiative, not all organizations contributed the same amount of data to this project. Figure 5 identifies the 11 RTCs, the year they entered the initiative, and the data sets for which they contributed information for this evaluation.

**Figure 5: Intensive Site Residential Treatment Centers in the Creating a Culture of Care Initiative and their Data Contributions**

<b>Grantee Organization</b>	<b>Year Joined the CCC initiative</b>	<b>Contributed to Emergency Behavioral Intervention Data (Y/N)</b>	<b>Contributed to ISRR/6CS Survey (Y/N)</b>	<b>Contributed to Focus Groups (Y/N)</b>	<b>Contributed to Training and Technical Assistance Survey (Y/N)</b>	<b>Notes</b>
<b>Athletes for Change</b>	2013	No	No	Yes	Yes	Newly established; not treating youth until 2013
<b>Autism Treatment Center, Inc.</b>	2012	Yes	Yes	Yes	Yes	
<b>Brookhaven Youth Ranch</b>	2012	Yes	Yes	Yes	Yes	
<b>Children's Hope (Lubbock)</b>	2012	Yes	Yes	Yes	Yes	Contributed EBI data for 2012 to 2014 only
<b>Children's Hope (West)</b>	2012	Yes	Yes	Yes	Yes	
<b>Children's Hope (Washington)</b>	2012	Yes	Yes	Yes	Yes	
<b>Hill Country Youth Ranch</b>	2011	Yes	Yes	Yes	Yes	
<b>Helping Hand Home for Children</b>	2013	Yes	Yes	Yes	Yes	
<b>Meridell Achievement Center</b>	2012	Yes	Yes	Yes	Yes	
<b>Roy Maas Youth Alternatives</b>	2012	Yes	Yes	Yes	Yes	
<b>Sinclair Children's Center</b>	2012	Yes	Yes	Yes	Yes	

## Survey and Focus Group Findings

Results from the 6CS survey of RTC administrators and findings from the focus groups with direct care workers identified similar themes as factors that contributed to a reduction in restraints. Both the survey and focus group participants identified that the 6CS approach to reducing seclusions and restraints was adaptable and valuable at their respective intensive RTC site. Moreover, the administrators and direct care staff of intensive RTC sites who reported a decrease in the number of restraints after implementing the 6CS identified which of the strategies they believed were integral to their success. These included:

- Engaged and supportive leadership (Strategy 1)
- Incorporating data into their prevention efforts (Strategy 2)
- Workforce training about preventing S/R use (Strategy 3)
- Individualized treatment approaches (Strategy 4)

Respondents indicated that Strategy 5 seemed challenging to implement. It aims to increase the inclusion of youth, families, and advocates into RTC services. Respondents continue to try to do this while complying with regulations and client confidentiality requirements. Youth are in residential treatment care because they need specialized and intensive support that most families are unable to provide. Moreover, the decision to involve families in treatment services is complex and an individual one. Family involvement in services may not be recommended if the long term goals for the youth do not include reunification or if a foster family has not been selected yet.

Regardless of their achievement in reducing S/R, the leadership and direct care staff at intensive RTC sites identified the following lessons from the CCC initiative. They are:

- Engaged and supportive leadership is critical to successful implementation.
- Incorporating data analysis in prevention efforts aids restraint reduction.
- Debriefing activities contribute important data to assist prevention efforts.
- Open communication among staff improves data collection and strengthens prevention efforts.
- Training helps workers feel supported and focused on a child's needs.
- Flexible and individualized treatment approaches to youth yields results.
- Staff plays a vital role in successful organizational change.

In the following paragraphs, each lesson learned is discussed in greater detail and followed by supporting quotes from focus group and interview participants.

### Research Question: How was the implementation of the Six Core Strategies achieved?

#### *Engaged and Supportive Leadership is Critical to Successful Implementation*

Each of the intensive RTC sites achieved varying degrees of implementation for each of the 6CS and their sub-strategies. However, intensive RTC site administrators recognized the importance of their role as leaders to facilitate the successful implementation of the 6CS. Eighty-three percent of survey respondents either agreed or strongly agreed that the leadership of their RTC participated in several ways to reduce S/R use. The ways identified included: (1) participating in S/R reduction team meetings; (2) playing a central role in the initiative; (3) regularly reviewing progress towards meeting the CCC initiative program

goals, and (4) maintaining active involvement in data assessment relevant to the CCC program goals.

Direct care staff concurred about the critical role RTC administration plays in a major initiative, such as implementing the 6CS. Focus group participants who reported success or progress with the 6CS indicated that they had leaders that were: (1) supportive of the initiative; (2) educated and aware of the principles of CCC and trauma-informed care and made efforts to share and disseminate this knowledge; (3) engaged with staff, including through frequent trainings and meetings; (4) directly involved with youth care and youth success, and (5) flexible with time and available to staff members for conversations and consultations. Often, leaders and administrators were the most effective advocates for shifting cultural norms within programs and pushing for change from the top-down as well as in collaboration with front-line staff.

*“They are in the units, in the buildings, around the kids.”*

*“Support and modeling expectations; they do what they say”*

*“Even the case manager’s door is always open; I like the relationship we have with them.”*

Based on existing guidance and research on the 6CS, TNOYS staff was intentional in selecting intensive RTC sites that had demonstrated leadership buy-in from the start. Even with leadership turnover in a few participating sites, leadership buy-in was a consistent and important factor.

Although an executive director or chief executive officer participated in the initiative’s goal to reduce S/R use, fewer RTCs had the involvement of a medical director. Twenty-two percent agreed or strongly agreed that the medical director participated in S/R reduction team meetings and played a central role in the initiative. Almost half of the responses were marked “not applicable” and some indicated that their facility “did not have a medical director” or their “medical director was not expected to play this role.” More than half of the respondents reported that they had implemented certain aspects of facility policies identified in the 6CS. These included: written policies and procedures, action plans; program documentation for recovery oriented care and trauma informed care; staff recognition programs, and oversight roles for staff for S/R interventions. Specifically, 77 percent of respondents identified that their RTC has written policies and procedures that identify S/R reduction as a goal.

### *Incorporating Data Analysis in Prevention Efforts Aids Restraint Reduction*

Intensive RTC sites recognize the importance of using data to inform practice and monitor change. All survey respondents indicated they had identified standard core and supplemental variables to monitor such as, incidents, use of involuntary medication, and injuries. More than three-quarters of survey respondents reported that they had “completed” or were “in the process of completing”: the collection of baseline data, sharing data with the S/R reduction team, observing and recording “near misses” of S/R use, and confidentially recording staff involvement in S/R interventions to identify training needs of staff.

Some intensive RTC sites' staff identified the value of using data to inform their work with youth. Using data (e.g. number of emergency behavioral interventions) and staff debriefings, staff discuss how the restraint could have been avoided and what, if any, of their actions could be changed to reduce the likelihood of a similar situation reoccurring.

*“We have data available in training five days a week; [it] gives you per staff containment data for the month...Now we haven't had a restraint in a while.”*

*“Data helps you know how treatment plans are doing. If a particular staff has more restraints, data helps narrow down who needs more training.”*

According to survey findings, goal setting activities were also in place, in progress, or planned with the majority of RTCs. Specifically, 94 percent had completed, were in the process of completing, or planned to complete setting performance goals and communicating these goals to staff. RTC leadership understood the importance of pinpointing their strengths as well as improving their weaknesses. Eighty-three percent of respondents said that they were benchmarking their progress against previously collected data, while only 44 percent completed benchmarking against comparable facilities.

### *Debriefing Activities Contribute Important Data to Assist Prevention Efforts*

The sixth core strategy is about promoting the use of analysis of every S/R intervention through debriefing techniques. RTC leadership recognized that analyzing what caused the restraint may help to avert future restraints. Almost all administrators (94 percent) used or are in the process of using analysis to gain an understanding of what could have been done differently and how similar situations could be avoided.

*“Once a month we talk about why restraints happen and what we could do next time so that we can collaborate. Weekly, our teams are assessing how they are functioning.”*

Various aspects of debriefing were implemented by the majority of RTCs. Specifically, 88 percent of RTC administrators identified that they had or planned to develop goals for debriefing sessions and a process for following up after the session. More than three-quarters of respondents reported that they had identified or planned to identify the roles and responsibilities, a process, and documenting debriefing sessions.

All survey respondents reported that they have implemented or are in the process of implementing the following procedures of immediate debriefing: making sure everyone is safe, ensuring the event is well documented, checking in with staff and witnesses, and returning milieu to pre event status. Getting to the root of the problem that caused the S/R intervention was used or in the process of being used by 88 percent of respondents.

### *Communication Improves Data Collection and Strengthens Prevention Efforts*

For some RTCs, communication and data collection work together to improve S/R prevention efforts. Communicating information between staff and between staff and youth played an important role in reducing restraints. RTC staff identified that good communication between direct care workers can help to identify “triggers” for certain youth. It may also help to identify patterns and the rationale for why a youth may be acting out.

Additionally, communicating with a youth, when feasible, about their actions, assisted staff and the youth in understanding the reasons for their behavior and alternatives to acting out.

*“[It is] important to explain why they [youth] were restrained so they understand.”*

*“The kids are way more open to telling you what bothers them. Before you wouldn’t have that and it would take years to figure it out.”*

Many RTC participants pointed to the necessity of successfully communicating expectations to ensure growth and success. This was referenced for both relationships between staff and the administrators as well as between staff and youth residents. For the RTCs reporting the most success, expectations were not only verbalized and outlined, but also modeled, posted publicly, and consistently demonstrated in action.

Relatedly, many RTC staff members commented on how rapidly youth respond to their environments: the communication styles used, the events occurring, and the overall culture or mood. Positively, youths responded to role models: staff members that take the time to communicate effectively, build a relationship, and connect through empathy. Multiple evaluation participants believed that it’s through these relationships and an atmosphere of respect that youth learn life skills and key elements of positive social interaction.

On the other hand, staff reported that youth seem to respond immediately and negatively to “weaker” members of staff, either by pushing the limits when a staff member was too lenient by coming into conflict with shows of authority; or by putting up a wall and shutting down entirely. One topic that came up frequently was how power struggles between staff and youth can easily escalate into a situation where a restraint must be used.

### *Training Helps Workers Feel Supported and Focused on a Youth’s Needs*

Developing and improving the workforce allowed for the creation of a treatment environment whose practices and policies were based on the trauma-informed paradigm. This type of environment provided multiple opportunities to integrate trauma-informed activities into the RTC. According to survey respondents, 94 percent of RTCs trained staff to use other methods instead of S/R practices and 100 percent of RTCs focused on teaching core therapeutic skills and relationship building.

A number of focus group and survey participants reported the importance of training and practice opportunities related to the new skills and a paradigm shift involved in the CCC initiative. These trainings included the following topics: positive youth development; working in collaboration with youth; the impact of trauma on youth; modeling positive behavior, and communication skills for building relationships and alliances with youth. All of the above training topics mentioned align with the 6CS. Those that participated in the 2012 initial 6CS and Building Bridges trainings, as well as the 2014 refresher sessions, reported the value of those trainings.

*“Training has helped me feel supported.”*

*“Staff development; proper staff training to assist with behaviors [were the most helpful parts of the Six Core Strategies].”*

*“Training when you start and every month in ways to talk to the child, de-escalation techniques. We have many we can choose from. We use them and are always learning new ways, new tools we can share that work with our kids, share with other, how [to] use what we have.”*

Empowering RTC staff was another aspect of workforce development that RTCs reported they adopted. To illustrate, 77 percent of survey respondents reported that they completed or are completing ways for staff to provide input on rules and policies and 55 percent used staff satisfaction surveys to solicit feedback to improve RTC policies and operations. Sixty-six percent of respondents recognized staff achievement publically and provided RTC staff confidential access to employee assistance programs.

### *Flexible and Individualized Treatment Approaches to Youth Yield Results*

The fourth core strategy focuses on the importance of individualized treatment and includes the use of assessment tools to identify risk for violence, S/R history, and serious illness; the use of a behavior scale to assist staff to match the intervention with the level of behavior observed; and safety planning. All survey respondents identified that they are either in the planning stages or have already implemented a trauma assessment of youth upon intake. They also used or are planning to use individual de-escalation or safety plans to identify triggers and effective emotional self-management interventions for youth. However, fewer respondents indicated that they had adopted behavior scales and procedures to use them.

Achieving an individualized approach to treatment planning and activities is linked with workforce development and collecting and using data to inform practices.<sup>35</sup> Most survey and focus group respondents that identified achieving a “better than expected” outcome saw a decrease in the number of restraints after implementing the 6CS. They reported that they were focused on individualizing elements of treatment, safety planning, and measuring youth outcomes. This included an emphasis on youth access to one-on-one time with staff members as needed. It also included knowing the history of each youth’s trauma, triggers, and personally identified calming techniques. This emphasis was in direct contrast to the more traditional institutionalized systems that include inflexible rules and schedules and behavioral management techniques.

*“Before we had more pre-determined consequences for particular behaviors. This approach did not work with every child. Now we are able to give more respect to each child: wonder why that happened, take it into consideration, get to the root of the behavior. Now we explain to the child why they are getting a consequence; they can pick their own consequences and understand why they are getting them.”*

RTCs that reported less success in implementing the 6CS had difficulty providing youth with one-on-one time with staff. While in some cases RTC staff did not see the value of individualized care, they more often did not see how it could be feasible in their daily schedules and programming.

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<sup>35</sup> National Association of State Mental Health Program Directors. Retrieved from Internet on April 19, 2015 from: [http://www.nasmhpd.org/docs/NCTIC/Consolidated\\_Six\\_Core\\_Strategies\\_Document.pdf](http://www.nasmhpd.org/docs/NCTIC/Consolidated_Six_Core_Strategies_Document.pdf)

*“You have to have your mind set on not relying on the other staff. But how can I do this? Some of my kids need longer.”*

*“It takes a long time to de-escalate and we need support in every problem.”*

### *Quality Staff Plays a Vital Role in Successful Organizational Changes*

Many evaluation participants indicated that the single most important element for success in the CCC initiative was hiring and retaining quality staff. RTCs reported that staff best suited to this type of work is emotionally invested, flexible, creative and disciplined. Most importantly, many identified great staff members were those that can remain calm and work collaboratively with colleagues rather than react easily to youth outbursts or input from colleagues and leaders.

For varying reasons, almost all survey respondents identified “staff” as a characteristic that made the implementing 6CS easier and/or more challenging. Two respondents made positive comments about staff. One identified that having masters-educated staff increased the comprehension of sophisticated teachings and interventions. Another identified their staff were flexible and dedicated and that contributed to easier implementation of the 6CS.

Conversely, multiple respondents indicated that youthful and inexperienced staff was a challenge to implementing 6CS. Training staff to put the resident first and their instincts second was noted specifically to be a challenge. Respondents saw that they needed to assist staff through increased training and leadership.

*“...[Staff need] to learn to get more involved with the residents instead of babysitting them.”*

*“[Staff] needed to curtail their own desire to punish the resident without explanation and [instead] helping him to process the situation.”*

# Analysis of Emergency Behavioral Intervention Data

## Research Question: What success was achieved in reducing seclusions and restraints?

Overall intensive RTC sites experienced a greater reduction in restraints from 2011 to 2013 than non-intensive RTC sites (non-participating RTCs) did for the same period of time. Specifically, from 2011 to 2013, intensive RTC sites reported a 25 percent decrease in the number of restraints reported, while non-intensive RTC sites reported an 11 percent decrease for the same period of time. Individually, intensive RTC sites varied in their ability to reduce restraints and seclusions. Only one intensive RTC site reported using seclusions and their progress to reduce their use varied each year of the initiative.

Nine of the eleven intensive RTC sites reported EBI data to DFPS from 2011 to 2014. Data were not available for the remaining two sites because one was sold and acquired new leadership, while the other was newly established and had not treated any youth yet. Further discussion about the limitations of EBI data can be found later in this report (see Chapter 8, Data Limitations).

### *Most Residential Treatment Centers Reduced Restraints; Levels of Success Varied*

RTC sites varied in their ability to reduce restraints and seclusions while participating in the CCC initiative, however seven sites experienced an overall decrease in the number of restraints reported from 2011 to 2013. A total of six sites reported a decrease in restraints from 2011 to 2012 or from 2012 to 2013; however, these were not the same six sites that reported decreases each year.

Of the nine intensive RTC sites, six reported decreases in restraints from 2011 to 2012. The reported reductions in restraint reports ranged from 34 percent to almost 100 percent. Of the three intensive RTC sites that reported an increase in restraints from 2011 to 2012, one did not join the CCC initiative until 2013, another experienced an increase of less than one percent, and the third site experienced a 36 percent increase.

From 2012 to 2013, 6 of the 9 intensive sites again showed a decrease in restraint reports, however it was not the same six sites that reported decreases the previous year. During this period of the initiative, the restraint reduction reports ranged from 4 percent to 100 percent. Two of the six that reported decreases from 2011 to 2012 reported increases during this time. These two sites reported 81 percent and 21 percent increases, respectively. Conversely, two sites that reported increases from 2011 to 2012, reported a 14 percent and a 54 percent decrease, respectively, from 2012 to 2013.

### *Seclusions Rarely Used by Most RTCs in the Creating a Culture of Care Initiative*

Only one intensive RTC site reported using seclusions. This site reported a 14.5 percent decrease in seclusion usage from 2011 to 2012 and a 9 percent increase the following year. Figure 6 shows the percentage change for reported restraints and seclusions for each intensive RTC site by year and the overall all percent change from the base year, 2011, to 2013.

**Figure 6: Percentage Change of Reported Restraints and Seclusions for Intensive Site Residential Treatment Centers, 2011 to 2013**

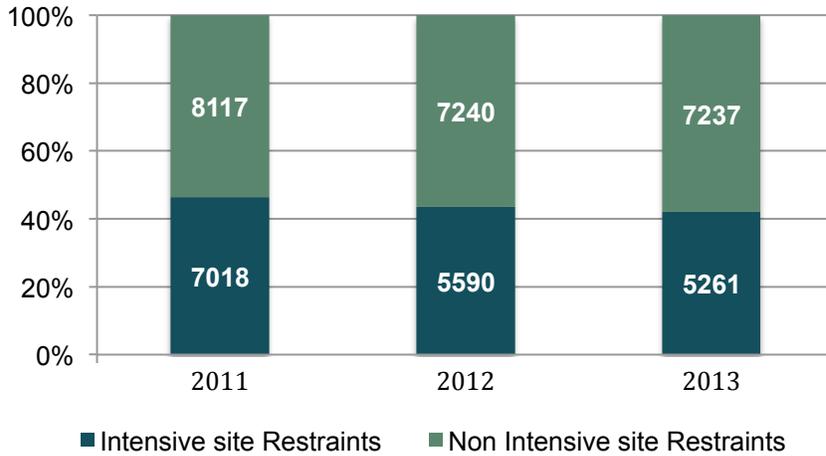
Grantee Organization	RESTRAINTS			SECLUSIONS	
	Percent Change from 2011 to 2012	Percent Change from 2012 to 2013	Percent Change from (Base Year) 2011 to 2013	Seclusion Percent Change between 2012 & 2013	Seclusion Percent Change between 2011 to 2013
<b>RTC 1</b>	NA	NA	NA	0	0
<b>RTC 2</b>	-55.3%	81.0%	-19.1%	0	0
<b>RTC 3</b>	-97.3%	-100.0%	-100.0%	0	0
<b>RTC 4</b>	NA	135.2%	NA	0	0
<b>RTC 5</b>	-34.0%	-4.0%	-36.6%	0	0
<b>RTC 6</b>	-47.7%	20.6%	-36.9%	0	0
<b>RTC 7</b>	16.4%	-13.8%	0.3%	0	0
<b>RTC 8</b>	0.3%	-53.7%	-53.6%	0	0
<b>RTC 9</b>	35.7%	155.1%	246.2%	-14.5%	9%
<b>RTC 10</b>	-63.5%	-66.8%	-87.9%	0	0
<b>RTC 11</b>	-72.7%	-41.5%	-84.0%	0	0

*Intensive RTC sites Account for Large Portion of Total Restraints and Seclusions Reported in State*

According data from DFPS, 85, 80, and 74 licensed RTCs operated in Texas in 2011, 2012, and 2013, respectively.<sup>36</sup> Of these facilities, 10 participated in the 3-year CCC initiative by contributing EBI data and were designated as intensive RTC sites. Interestingly, 10 of the 11 intensive RTC sites accounted for almost half of all reported restraints or 46 percent in 2011 and more than more than 40 percent in 2012 and 2013. Figure 7 shows the total numbers of restraints reported by intensive and non-intensive sites and their proportion of all reported restraints from 2011 to 2013. The proportion of total restraints attributable to the intensive sites decreases slightly in 2012 and 2013 to 44 percent and 42 percent, respectively.

<sup>36</sup> Retrieved on August 8, 2015 from [https://www.dfps.state.tx.us/About\\_DFPS/Data\\_Books\\_and\\_Annual\\_Reports/2014/pdf/7RCLAll.pdf](https://www.dfps.state.tx.us/About_DFPS/Data_Books_and_Annual_Reports/2014/pdf/7RCLAll.pdf)

**Figure 7: Total Number of Restraints Reported by Intensive and Non-intensive sites, 2011 to 2013**



Source: Texas Department of Family and Protective Services

As previously stated, only one intensive RTC site in the CCC initiative continues to report using seclusions. The percentage of seclusions used by this one intensive site increased from 2011 to 2013. Figure 8 shows the total numbers of seclusions reported by the intensive site and the non-intensive sites, as well as the proportion of seclusions reported by both groups.

**Figure 8: Total Number of Seclusions Reported by Intensive and Non-intensive sites, 2011 to 2013**



Source: Texas Department of Family and Protective Services

According to data from DFPS, this one intensive RTC site accounted for 22 percent of all reported seclusions in the state and that percentage grew to 30 percent by 2013.

The number of seclusions reported by non-intensive RTC sites declined sharply from 2012 to 2013 from 936 to 669 or 29 percent. The intensive RTC site did not report as sharp of a decline in 2013, which may explain the increase in the proportion of total seclusions attributed to it.

### *Intensive Site Residential Treatment Centers Achieved Greater Reductions than Non-Intensive Sites*

From 2011 to 2012 there was a 20 percent reduction in the number of restraints reported by intensive RTC sites and an 11 percent reduction in the number of restraints reported by non-intensive RTC sites. The next year continued to show a drop in restraint reports, but not as great as the previous year. From 2012 to 2013 the percentage of reported restraints dropped by 6 percent for intensive sites and non-intensive sites remained steady. Figures 9 and 10 show the percentage change of restraint and seclusion reports per year for intensive and non-intensive sites, respectively.

**Figure 9: Residential Treatment Center Intensive Sites Restraint and Seclusion Reports Percentage Change by Year, 2011 to 2014**

Percent Change Previous Year	Year	Personal Restraints	Seclusion
<b>Intensive sites only</b>	2011	N/A	N/A
	2012	-20.3%	27.3%
	2013	-5.9%	-14.5%
	2014	-55.9%	-61.1%

Note: 2014 Data is incomplete and consists of January to June 2014.  
Source: Texas Department of Family and Protective Services

**Figure 10: Residential Treatment Center Non-intensive Sites Restraint and Seclusion Reports Percentage Change by Year, 2011 to 2014**

Percent Change Previous Year	Year	Personal Restraints	Seclusion
<b>Non-Intensive sites only</b>	2011	N/A	N/A
	2012	-10.8%	-0.7%
	2013	0.0%	-28.5%
	2014	-66.2%	-62.9%

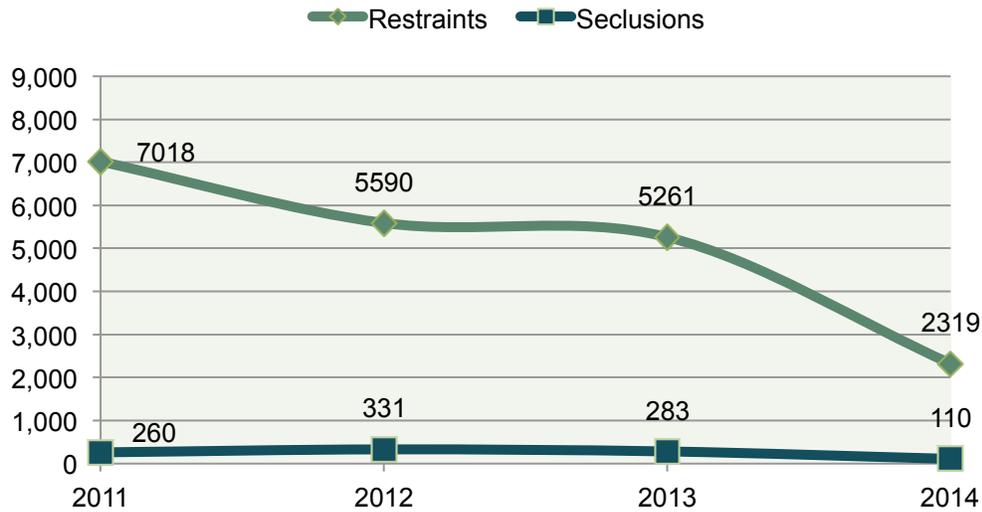
Note: 2014 Data is incomplete and consists of January to June 2014.  
Source: Texas Department of Family and Protective Services

Overall from 2011 to 2013, a 25 percent reduction occurred in the number of restraints reported by intensive RTC sites, while non-intensive RTC sites report an 11 percent reduction for the same period of time.

### *All Residential Treatment Centers Reported Fewer Restraints Since 2011*

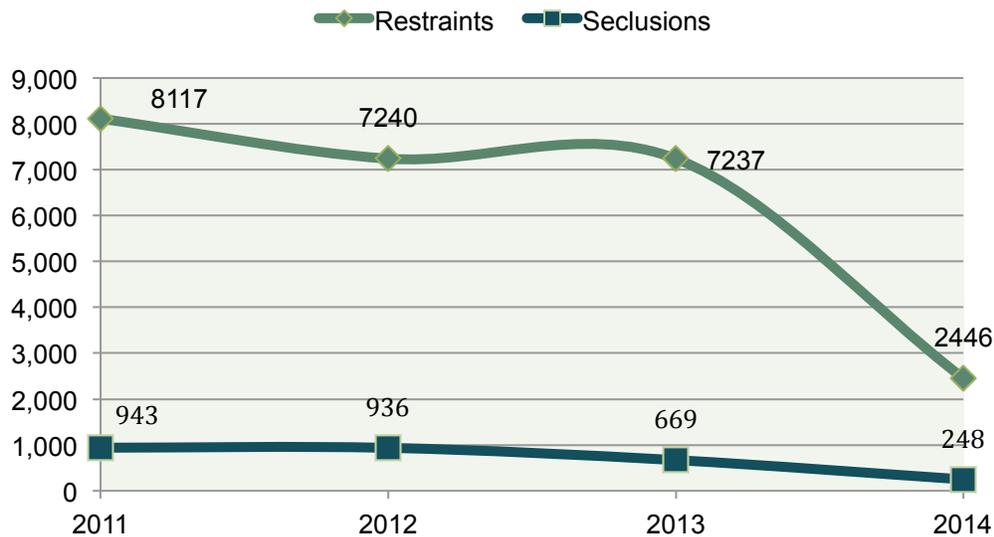
The decrease of restraints reported by the intensive RTC sites cannot solely be attributed to the implementation of the 6CS because restraint usage overall trends downward from 2011 to 2013 for both intensive and non-intensive sites, as shown in Figures 11 and 12.

**Figure 11: Intensive Site Restraint and Seclusions Totals, 2011 to 2014**



Note: 2014 Data is incomplete and consists of January to June 2014.  
Source: Texas Department of Family and Protective Services

**Figure 12: Non-intensive sites Restraints and Seclusions Totals, 2011 to 2014**



Note: 2014 Data is incomplete and consists of January to June 2014.  
Source: Texas Department of Family and Protective Services

Most of the intensive RTC sites implemented the 6CS framework during the second quarter of 2012 and one site implemented it during the third quarter of 2012. However, the number of restraints reported by intensive sites started to decline in the third quarter of 2011 which is prior to the start of the 6CS training, as shown in Figures 13.

Non-intensive RTC sites showed earlier declines in the number of reported restraints beginning in in second quarter of 2011, as Figure 14 shows. However, non-intensive sites spiked in the third quarter of 2012, while the intensive sites continued to decline steadily

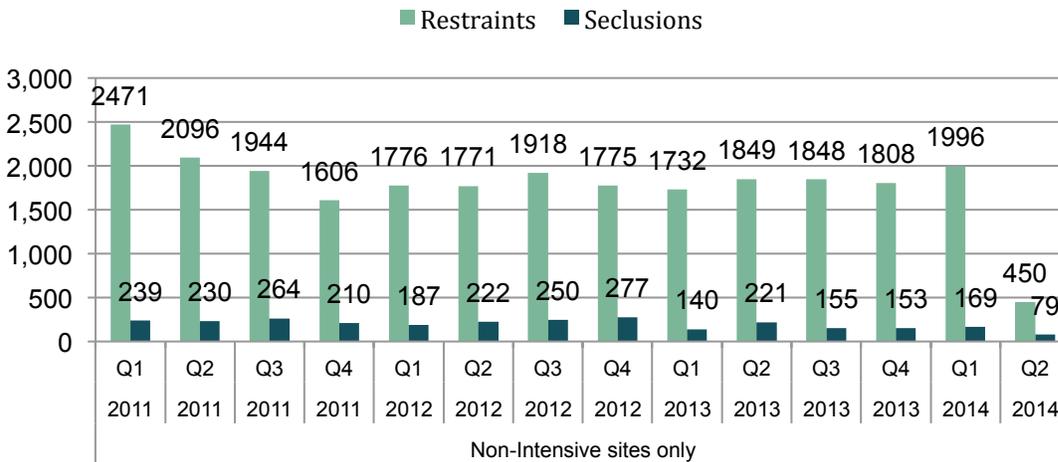
from third quarter of 2012 to the second quarter of 2013. Both intensive and non-intensive sites reported a spike in the number of restraints reported in the third quarter of 2013.

**Figure 13: Total Number of Restraints and Seclusions Reported by Intensive Residential Treatment Sites by Quarter, 2011 to 2014**



Note: 2014 Data is incomplete and consists of January to June 2014.  
Source: Texas Department of Family and Protective Services

**Figure 14: Total Number of Restraints and Seclusions Reported by Non-Intensive Residential Treatment Sites by Quarter, 2011 to 2014**



Note: 2014 Data is incomplete and consists of January to June 2014.  
Source: Texas Department of Family and Protective Services

# Influences Affecting Implementation of Six Core Strategies at Residential Treatment Centers

## Research Question: What contributed to making the Six Core Strategies easier or more challenging to implement?

Findings from focus groups included themes regarding factors that contributed to success and challenges with implementing the 6CS at some RTCs. Note that not all of the following themes emerged through data from every RTC, but all of the following themes emerged from one or more RTCs that participated in CCC and therefore shed light on factors that may influence the success of implementation of the 6CS.

### *Education about Trauma-Informed Care Extends to Staff Evaluations and Recruitment*

Evaluating staff about their competencies in trauma-informed care practices provides RTCs and their staff with continuous information and opportunities to hone their skills. All survey respondents indicated they have completed or are in the process of completing using observation and various other mechanisms (e.g. employment counseling, performance improvement reviews) as techniques to review staff's skills. Additionally, 94 percent of respondents indicated they have completed this or are in progress of training staff in areas where they lack competence.

Education about trauma-informed care practices extends to prospective workers too. Nearly all survey respondents (94 percent) indicated that trauma-informed care information is included in new hire orientation and 50 percent of respondents included trauma-informed care information in job interviews and advertisements.

### *Restraint and Seclusion as Tool or Consequence*

Most intensive RTC sites see EBIs as a “last resort” to be used in crises to prevent youths from hurting themselves or others. Staff members in focus groups spoke to the fact that youth often don't understand consequences when administered in a traumatic way, such as through restraints and seclusions. It is more effective to take time to help youths understand why they were receiving consequences rather than simply punish, which can help change future behavior. However, certain direct care staff members lamented the loss of punishments and consequences, including S/R, as a tool to “keep kids in line.” Staff members felt that they were not able to promote accountability or attain respect from youths without using such strategies or consequences.

*“What is wrong with discipline? We are not allowed to do any, give any consequences, and there's nothing we can do about it, even if they slap us.”*

### *Matching Youth to Programs*

In addition to appropriately screening staff, some RTCs pointed to the need to adequately screen youth prior to intake. At least three participating RTCs reported the increased difficulty of treatment for youth that are inappropriate for their program, including very low functioning, those with autism, or extremely impulsive youth. Moreover, at least some staff commented that sometimes they receive youths that should not be there, (e.g., low-

functioning and impulsive) which hampers their ability to initiate reform due to attention deficits caused by overworked staff.

*“When you have kids who need and deserve positive attention but I’m so focused on this kid who is threatening. I have apologized that I am unable to give you [the youth] the attention...”*

During the course of CCC, multiple participating RTCs became increasingly selective in accepting youth into their program, specifically identifying their program’s areas of strength (e.g., with younger children; with sex offenders; with youth with no history of elopement). This practice was not explicitly a goal of the CCC initiative, but may have been correlated with reductions in S/R interventions as part of an overarching culture change process.

*“They [the administrators] now have a better sense of which kids will be more successful here and are able to select kids based on their proclivity to succeed”*

### *Inadequate Staffing Ratios and Salaries*

Several participants reported feeling limited by staff-youth ratios or overwhelmed by managing a group of youth with diverse and challenging behaviors. Beyond that, respondents reported that they did not feel able to approach leadership or other staff members for support or to “swap out” when there was a need to work with a youth individually to de-escalate or debrief. Respondents reported that the ability to rely on colleagues and step away from the treatment milieu is a key element in avoiding burnout.

*“You cannot rely on other staff to cover the rest of your kids when you are debriefing one.”*

Many RTCs struggle with high turnover rates due to low pay, a need to maintain ratios, and insufficient screening methods. Also, a few participants from more remote areas of the state reported the challenge of finding appropriate candidates in small, rural communities. This combined with the inability to offer wages that will attract people from larger cities present a significant obstacle for some rural RTCs to overcome.

*“Lowest paying job in town.”*

*“Lot[s] of turnover. A lot of people don’t know what to expect and it don’t work that way so they leave.”*

*“Most of the ones who leave, [leave] before 90 days. If you make it past a year, you’ll stay.”*

## Research Question: What practices of training and technical assistance are preferred by residential treatment staff to assist with the implementation of Six Core Strategies?

As part of the evaluation, TNOYS staff sought feedback about the training and technical assistance they provided to the intensive RTC sites. The survey was distributed via email during April 2014 with an attached link to it. TNOYS staff requested that three different staff from each intensive site complete the survey, however at least one staff from each RTC completed the survey. Respondents answered all multiple-choice questions; however, not all respondents chose to add additional information in the open-ended questions.

Throughout the CCC initiative TNOYS staff used multiple types of training and technical assistance to help intensive RTC sites with their implementation of the 6CS. Figure 15 shows the various types of assistance that was offered:

**Figure 15: Types of Training and Technical Assistance Texas Network of Youth Services Staff Provided to Intensive Site Residential Treatment Centers**

- 1 Regional trainings hosted by TNOYS
- 2 Personalized trainings RTCs requested from TNOYS for your RTC
- 3 Facilitated meeting and networking opportunities with other RTCs
- 4 Conference calls hosted by TNOYS
- 5 Phone calls or emails related to specific questions asked of TNOYS
- 6 Emails with attached resource materials such as articles, links to web resources, etc. requested from TNOYS
- 7 Items sent out from the TNOYS library (books, videos, etc...)
- 8 Visits and brainstorming meetings with TNOYS at RTC facilities
- 9 Travel reimbursements for RTCs (to attend trainings, conferences, meetings, etc...)
- 10 Discretionary funds (for comfort/sensory/calming rooms, staff recognition, etc...)
- 11 Communications pieces (photos, news-releases, newsletters, etc...)
- 12 Groupsite participation
- 13 Scholarships to attend the TNOYS Annual Conference

### *Individualized Training and Networking Most Useful Forms of Support*

Overall, intensive RTC sites identified in-person contact as their favorite type of support. Various respondents characterized face-to-face meetings through trainings with TNOYS staff or networking opportunities with peers as beneficial support.

*“Networking with the other RTCS; it is always great to share ways to motivate their staff because we are all working toward the same goals.”*

*“On-site training by TNOYS...Focus on utilizing de-escalation techniques.”*

To assist with motivating intensive RTC site staff throughout the initiative, TNOYS provided RTCs with multiple opportunities to network with their peers and receive personalized assistance. These types of assistance were identified as being the most useful. The ability to discuss issues with peers and establish a reliable network of peers to look for new solutions to sector-wide problems was a persistent theme in survey responses.

*“The on site visit helped us the most.”*

*“Talking to other administrators at a variety of programs and being able to ask real ‘nuts and bolts’ questions rather than just broad philosophical questions.”*

### *Discretionary Funds Proved Useful for Training and Supplies*

Some respondents identified the use of discretionary funds as being very useful. TNOYS and the Hogg Foundation offered each site an opportunity to apply for \$1,000 to use toward the development of a calming room or related supplies. Five sites took advantage of the funding to purchase items such as weighted blankets, sound machines, and incentives for staff to reduce their use of restraint. Respondents identified the scholarships for RTC staff to attend statewide conferences as helpful too because it allowed direct care staff to interact with peers and see how RTC services fit into the wider child welfare system.

*“Again, the trainings provided by TNOYS staff at the facility as well as the Annual Conference. It helped open direct care staff eyes to the ‘bigger picture,’ helping them understand our facility is part of a greater system and that our jobs reach far beyond our local area. Opened them up to new ideas in working with children and not so ‘resistant to change.’”*

### *More In-Person Technical Assistance is Preferred*

When respondents were asked what TNOYS could have done differently regarding the training and technical assistance they provided, the most often mentioned answers were more face-to-face visits and more training on specific topics. Some respondents identified more convenient training locations and one expressed disappointment about the participation level on conference calls.

*“Even more face-to-face visits. This was difficult due to distance.”*

*“I had hoped for more participation on the monthly conference calls.”*

## Data Limitations

### *Small Sample Size*

Given that the CCC initiative was a pilot project, a small sample size of Texas RTCs received intensive support. The sample of RTCs that volunteered to participate in the CCC initiative is not representative of all licensed RTCs in Texas. For multiple reasons the self-selection of RTCs into the initiative impacted how representative the group was of all Texas RTCs. For example, a self-selecting RTC may have innovative leadership that is continually looking to improve the delivery of care or the reverse may be true. This group of RTCs may have ongoing challenges and their staff may use S/R interventions more frequently. As previously mentioned, 10 of the 11 intensive RTC sites accounted for almost half of all reported restraints or 46 percent in 2011 and more than more than 40 percent in 2012 and 2013. In either case, each RTC may have unique characteristics that prevent them from being representative of all Texas RTCs.

### *Emergency Behavioral Intervention Data Has Limitations*

EBI data has several limitations and may not be an accurate indicator of an RTC's success to reduce S/R. EBI data is self-reported data by RTC staff. Limited auditing of the data is performed to ensure its accuracy.

The knowledge and understanding of RTC staff about what interventions qualify as a restraint or seclusion can impact what incidents get reported. In either case, without proper understanding or consistent interpretation of definitions and regulations the S/R data may be under or over-reported.

While the number of restraints and seclusions are collected from RTCs, a quarterly census of youths served at each RTC is not collected simultaneously to use for comparison between facilities. This prohibits additional analysis, such as being able to determine if changes in S/R use are due to an increase in census, inadequate staffing ratios, or other similar factors. EBI data appear to be somewhat "seasonal," with distinct quarterly trends in the number of S/R interventions. Stakeholders theorize that this may be due to an influx of youths admitted to RTCs at certain times during the year. This makes it difficult to distinguish the true impact of a facility's S/R reduction efforts.

Most RTCs are divided into cottages or separate units within the RTC to allow for more manageable group size and a home-like atmosphere. Despite an RTC's selection to be an intensive site for the CCC initiative, not every cottage or unit at the RTC may have implemented the 6CS consistently. Therefore, inconsistency may minimize the visible impact of the implementation of the 6CS at a specific RTC when looking at EBI data, given that EBIs are reported as a total for the RTC and are not unit-specific.

### *Residential Treatment Center Selection of Youth*

Assessing youths to ensure an RTC can meet their therapeutic needs can be viewed positively or negatively. Some RTCs are more selective in admitting youth to their program than other RTCs, which may accept every referral. While an improved selection process can better match youth to a center's treatment offerings, selectivity may also be viewed as "cherry-picking" where only the least complex youth are admitted for services. Selective RTCs may utilize fewer seclusions and restraints and subsequently report fewer EBIs to state regulators. This presents a challenge when comparing EBI data between RTCs.

The demographics and health status of the treatment population are factors that exert considerable influence on the number of S/R a RTCs reports. For example, if a youth is not developmentally able or ready to understand the reasons for his/her behavior or what causes it, then s/he may not be able to fully participate in debriefing after the intervention, thereby resulting in little to no information being learned about how to prevent similar situations. Moreover, a population who is unable to communicate effectively with staff about their behavior or thoughts may have similar difficulties.

### *Emergency Medication Use Was Not Evaluated*

EBI data measures more than restraints and seclusions. It also includes emergency medication. This evaluation did not measure the impact the 6CS had on the intensive sites' use of emergency medication as a form of restraint. Without an evaluation of emergency medication usage, it is not known what relationship emergency medication has with other S/R usage. Implementation of the 6CS may reduce the use of emergency medication as well as traditional S/R practices. Alternatively, use of emergency medication may be inversely related and increase as S/R usage decreases because staff is substituting one type of EBI for another.

### *Incomplete Data for Duration of Initiative*

EBI data was incomplete for 2011 and 2014. One intensive site did not have any EBI data for 2011 due to a change in ownership and at the time the CCC initiative's conclusion only the first two quarters of data for 2014 was available. Therefore, only two complete years (2012 and 2013) of data could be used for analysis of EBI changes.

The proposed evaluation plan intended to seek input from youth at RTCs to triangulate organizational changes. Seeking youths' perspective was important because some changes may have been more easily perceived by youth in care and not staff or RTC leadership. DFPS officials denied TNOYS staff's request to survey youth at RTCs.

### *Variable Intensity of Technical Assistance*

The intensity of technical assistance that the Children's Hope RTCs received from TNOYS may have varied from other initiative sites and may have affected their implementation of the 6CS. A coordinator from each RTC liaised with TNOYS staff throughout the initiative. However unlike the other RTCs in the initiative, Children's Hope has three geographically different locations, but used only one coordinator. Consequently, TNOYS technical assistance was divided among three locations instead of concentrated to one as with the other initiative RTC sites.

## Lessons Learned

Valuable lessons were gleaned from the CCC initiative that may prove useful to other RTCs choosing to implement S/R reduction practices. As with other organizational culture change movements, leadership (Strategy 1) plays a critical role in the degree of success it achieves. RTCs administration and direct care staff both echoed the importance of leadership during implementation of the 6CS. Leadership can model behavior to staff as well as support and encourage them to continue their efforts before tangible results appear. Incorporating data (Strategy 2) into S/R reduction efforts will allow staff to identify when tangible results are achieved. Facilitating communication between staff and recording information from debriefing sessions (Strategy 6) can improve staff's understanding about why a S/R intervention occurred and improve prevention efforts.

Staff is a vital part of the equation when implementing culture change at an organization. In addition to leadership buy-in, staff buy-in is another critical element. The RTCs that reported less turnover and higher staff satisfaction appeared to have more success with the CCC initiative. Almost all survey respondents identified staff for varying reasons as a characteristic that made the 6CS easier and/or challenging to implement. RTCs with trained and experienced staff identified them as a positive aspect when implementing the 6CS while RTCs with younger and inexperienced staff identified staff as a challenge.

As with learning any new skill, staff need proper training (Strategy 3) to feel competent in their mastery of it. Moreover, RTC staff participating in the CCC initiative reported the importance of training and practice opportunities to gain confidence and competence. They expressed the value of refresher training courses to hone their newly acquired skills and that the greatest benefit about the de-escalation techniques they learned was that it placed their focus back on the child's needs and how they could assist him or her. RTC administrators demonstrated that they value workforce development too. All RTC administrators participating in the CCC initiative reported training their staff in S/R reduction techniques and developing and/or improving staff's core therapeutic skills.

Of the RTCs that achieved a reduction in restraints, providing youth individualized treatment instead of a "one size fits all" approach yielded results. Safety planning as well as collecting information through assessment tools (Strategy 4) to identify risk for violence, S/R history, and serious mental health diagnoses are two of the methods they used to identify individual triggers and effective emotional self-management interventions for youth in their care. Youth at these RTCs had access to one-on-one time with staff members as needed.

In addition to the lessons learned to improve future implementation of the 6CS, this evaluation identified challenges that inhibited its implementation in some RTCs. Some RTC staff did not like not being able to use S/R. They viewed S/R use as a consequence of the youth's actions and believed it held the youths more accountable.

Issues related to staffing continued to be mentioned by administrators and direct care staff. Several staff reported feeling limited by staff-youth ratios or overwhelmed by managing a group of youth with diverse and challenging behaviors. Their concerns were reinforced by administrators' concerns about turnover rates and the challenge of finding appropriate employees in small, rural communities and the inability to offer wages that will attract people from larger cities.

Despite the obstacles to implement Strategy 5, which would increase opportunities for youth, families, and advocates to be involved in RTC services, some RTCs were making strides in this area. Specifically, 35 percent of the respondents were allowing youth to serve on key executive committees and ensuring that staff appropriately includes youth. Of the six methods RTCs were surveyed about how to include youth, 82 percent identified that they created choices at every opportunity for youth as something they currently did or were in the process of doing. None of the RTCs identified that they had created or were in process of creating paid staff roles for eligible family members of youth. However, 83 percent of respondents identified that they encouraged or are “in the process of encouraging” families to attend treatment meeting planning and 94 percent identified that they train or are “in the process of training” staff to regard families as important participants in programming.

RTCs also seemed to struggle with how to fully include advocates too. No respondents indicated that they had or were in the process of creating paid staff roles for advocates and only one respondent indicated that they provide satisfaction surveys to advocates. However, 64 percent said they invited or planned to invite suggestions about how stakeholders could be more involved.

Finally, across the board, RTC leaders and staff identified that maintaining momentum in organizational change efforts is vital. When TNOYS or RTC sites experienced staff turnover, momentum slowed. Yet, certain factors seemed to support momentum, including having outside support, ongoing training and technical assistance opportunities, and the chance to network and brainstorm about challenges with other RTCs around the state. The participating RTCs appreciated being part of something bigger than their own site.

## Recommendations

Several major recommendations emerged from this evaluation for RTCs and other residential programs, policymakers, regulators, advocates, funders, and researchers. The following are recommendations for each respective group:

### *For RTCs and other residential programs:*

- Identify effective methods to hire and retain quality staff, especially in rural areas. This includes staff recruitment, training, pay and other incentives, career ladders, and strategies for preventing burnout.
- Continue to invest in and seek out continual opportunities for quality training and support, including training in de-escalation and individualized treatment. This is especially important for new and direct care staff.
- Seek external assistance when enthusiasm for S/R reduction wanes or when RTC staff is “stuck” in negative patterns.
- Communicate, connect, and consult with other facilities. Make site visits to see their treatment environments. Consider networking and consultation opportunities, like think tanks, focus groups, and forums.

### *For policymakers, regulators, advocates, and funders:*

- Provide support, including needed training and technical assistance, to assist RTCs in achieving successful organizational culture change that reduces S/R use.
- Hold RTCs accountable for reducing use of seclusion and restraint practices but do so in a manner that recognizes limitations and variability between programs.
- Identify and collect other measures/data that can provide context to S/R usage at RTCs and improve the value of EBI data. For example, collect quarterly census data for Texas RTCs to provide a denominator for EBIs to facilitate the analysis of changes over time and comparisons between RTCs.
- Seek opportunities to educate policymakers and state regulatory agencies about provider challenges. This could include observations at RTCs, periodic meetings with the state agency leaders, and other informal meeting opportunities.
- Participate in local and state coalitions with other provider groups to streamline regulations and ensure they fully support organizational culture change to reduce S/R usage.

### *For future research:*

- Identify factors that may explain why the intensive sites generated almost 50 percent of restraint reports from 2011 to 2013.
- Research the extent to which emergency medication rates were impacted by restraint reduction efforts.
- Identify the impact of additional factors at RTCs, such as census data. In other words, identify how restraint rates varied by number of residents in a given time period.
- Use the lessons learned from this project when planning for further research on integrating the 6CS and evaluating their impacts on restraint reduction.

## Conclusion

The CCC initiative adds to previous research and demonstrates that reducing S/R usage through organizational culture change can be successful. Multiple states and a variety of individual healthcare and treatment settings have adopted strategies and achieved positive and sustainable results, as Hogg Foundation funding was used solely for training, technical assistance, and grant coordination by TNOYS staff. Moreover, RTCs participating in the CCC initiative did not expend any funds to achieve their results. Leaders at the RTCs that participated in CCC made commitments to change their organizational cultures so that better outcomes for youth in their care could be achieved. The majority of them were successful. Consequently, this is an important wake-up call to treatment settings that rely heavily on S/R use to ensure a safe environment for clients and staff to let them know that implementing organizational change to reduce S/R use can be accomplished now.

More importantly, the CCC initiative serves as evidence to state regulators and policymakers that organizational culture change to reduce S/R use can successfully occur. Replicating the CCC initiative presents a win-win opportunity for all stakeholders: RTCs, the youth, and regulators/policymakers. The CCC initiative has revealed a rare opportunity—one in which an initiative with minor cost implications can be implemented within the existing regulatory structure and can result in improving the safety of the therapeutic environment for staff and clients. This is an opportunity not to be passed up or overlooked, but should be implemented immediately. Reducing seclusion and restraint practices presents an opportunity to quickly make a dramatic difference in the lives of children and youth who may have encountered extensive trauma already.

## Appendix

### Promising Practices from the Field for Implementing the Six Core Strategies

The CCC initiative evaluation offers a rich supply of data to support the understanding of what is effective in RTCs when working to reduce S/R practices while integrating a trauma-informed care philosophy. Over the course of the initiative, TNOYS staff observed and learned of a number of creative and promising practices from participating RTCs that the evaluation data does not fully capture. Below are highlights of these practices as they relate to specific strategies from the 6CS framework.

#### *Strategy One - Effective Leadership in Organizational Change*

The leaders at one RTC held regular “culture of care celebrations” for youth and staff. These were fun events such as pizza meals, movie screenings, and Friday afternoon parties that were highly anticipated by participants. During a site visit to this RTC, TNOYS staff observed colorful flyers around the facility advertising the next event as well as hearing youth expressing positive comments about it. Youth participated by giving their opinions to the event coordinator to help with its planning. All youth and staff were invited to attend; and, these events were not an earned privilege or connected to any behavior ranking systems for youth, a practice common in other RTCs.

At least two participating RTCs dedicated funds to staff recognition and incentives (e.g., gift cards, additional days off). The leaders at these sites made the choice to reward staff for their CCC initiative efforts and to bolster staff morale. Both sites reported a big return on their small investment to demonstrate their appreciation for staff. The impact the rewards had on staff far exceeded the administration’s expectations.

Another RTC implemented a leadership witnessing approach to restraints. This is recommended in the 6CS framework. When a restraint is about to occur – or is in process – at any time of day or night an administrator is called to the scene. This elevates the importance of restraint incidents and gives leaders a hands-on role in supporting youth and staff. Additional research is needed to understand how this practice may support a significant reduction in restraints. According to anecdotal evidence, this site did report a drop in restraint incidents after initiating this practice.

#### *Strategy Two - Using Data to Inform Practice and Monitor Change*

Participating RTCs collected and used their EBI data in a variety of ways. One RTC posted in a central location specific for all staff to see the data for monthly restraints as well as youth outcomes. This practice helped staff “connect the dots” and appreciate the value of data collection and documentation. Both leaders and mid-level managers reported their staff was more engaged now that they understood the relevance of the required paperwork.

Another RTC took a similar and simpler approach. They posted the “number of days without a restraint,” in a public and central location for all staff, youth, and visitors to see. This method identified the importance of S/R reduction was to the organization.

#### *Strategy Three - Workforce Development*

All participating RTCs and others who attended TNOYS trainings expressed the need for staff development and training on a variety of topics beyond trauma-informed care basics. TNOYS staff provided select opportunities and advised RTCs that were seeking more.

Additionally, TNOYS staff initiated and supported site-to-site mentorships as a low-cost, practical method of staff development. This included identifying RTC strengths, matching sites to one another, and providing logistical and financial support for site visits. Site-to-site support was the centerpiece of annual meetings and retreats. The RTCs that took advantage of these opportunities saw viable solutions in action at a site similar to theirs. and forged connections with colleagues for future problem-solving needs.

#### *Strategy Four - Identifying and Managing Conflict/Violence Risk Factors and Implementing Trauma Sensitive Treatment Services*

This strategy includes a number of sub-strategies related to trauma assessments, environmental changes, and individualized treatment approaches with youth. All sites addressed this strategy in some way, and some of the simplest, most visible environmental changes stand out. At least three participating RTCs made changes to the colors and feel of their settings. Staff at one site, together with youth, painted murals on their interior walls and converted a former seclusion room into an elective “quiet room.” At another site, an unused room became a sensory room complete with textured toys and therapeutic tools as well as weighted blankets that youth could try out. Finally, a third site worked with TNOYS staff and an interior designer to research soothing paint colors before re-painting their entire facility.

#### *Strategy Five - Youth/Family Advocacy Roles in Care Setting*

This strategy presented the most challenge and the most promise for participating RTCs. For many, working in true collaboration with youth was a new and scary prospect, and working with the families of youth in foster care seemed especially difficult. While TNOYS was not granted permission to talk to youth directly, many seeds of culture change were observed related to youth, family, and community engagement.

The following are some of the promising practices that stood out:

- Identifying certain youth at the RTC to provide the orientation tour and talk to new youth on their first day in treatment. The youth would talk with the arriving youth and tell them from a peer perspective what the RTC is like and their initial feelings upon arrival.
- Creating youth councils that meet regularly and give feedback on a variety of topics (e.g., celebration themes, kitchen menu, outings, how safe the facility feels, etc.).
- A video project with youth reporting back about their experience in the RTC and after.
- Holding family visit days at the RTC and supporting youth before, during, and after contact with family members. This is significant because certain RTC leaders understood the value of these experiences, but also saw the potential stress they caused (e.g., family members attending one time and then falling out of touch; parents asking youth to hold drugs for them; family members attending for some youth and none attending for others).
- Establishing community connections through outings and by hosting volunteers in the RTC. This was intended to address two different goals: providing youth with “real-world” experiences and mentor figures when family members were not available, as well as anchoring the RTC in its community as a place of healing.

In addition, TNOYS staff collaborated with the national expert trainers to include youth and family members (siblings and parents/caregivers) with lived experience in RTC settings in special training events to model effective partnerships and elevate youth and family voice.

### *Strategy Six - Debriefing Techniques*

Debriefing is mentioned throughout this report as a key strategy for participating RTCs. RTCs experimented with debriefing techniques to make these practices relevant and useful for youth and staff, instead as a formality or documentation burden. One RTC began the initiative with enthusiasm. Its leaders vocalized the idea that “all restraints are avoidable” and emphasized the debriefing process. However, they quickly learned that this was having an unintentional punitive effect. Some youth and staff felt chastised when recounting the incident. Consequently, they adjusted the process (and documentation) to emphasize that each situation is a learning opportunity, mistakes may happen, and reducing restraints is a process that occurs over time.

## Definition of Terms

To ensure a common understanding of key terms used throughout this report, Figure 16 shows their definitions.

**Figure 16: Definitions of Key Terms, 2015**

Texas Residential Treatment Center (RTC)	A general residential operation for 13 or more children or young adults that exclusively provides treatment services for children with emotional disorders
Trauma-informed care (TIC)	An organization and/or the services that address the dynamics and impact of complex trauma using systems to avoid inadvertently re-traumatizing consumers when providing assistance within the mental health system.
Seclusion <sup>37</sup>	The involuntary confinement of a person in a room where they are physically prevented from leaving or they believe they are for any period of time
Restraint <sup>38</sup>	Any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's body.
Emergency Behavioral Intervention (EBI) <sup>39</sup>	Action used in an emergency situation to prevent a person from self-harm or harming those around him/her. It may include personal restraints, mechanical restraints, emergency medication, and seclusion.
Intensive site residential treatment center	DFPS licensed RTCs that applied and were accepted into the CCC initiative. They received training and technical assistance from TNOYS staff.
Non-intensive site residential treatment center	DFPS licensed RTCs that did not apply and/or were not accepted into the CCC initiative. They did not receive individualized training and technical assistance from TNOYS staff.

## Background Information About the Intensive Site Residential Treatment Centers

The RTCs selected to be intensive RTC sites for the CCC initiative are diverse in several ways: geographically, capacity, staffing, population served, and reason for participation. Despite the differences in each of the sites, findings indicate that the 6CS framework was adaptable and valuable to all RTCs regardless of the amount of EBI reduction reported after its implementation.

TNOYS staff surveyed administrators from the 11 intensive RTC sites during the third year of the grant (2014) to get their thoughts and impressions about the 6CS's impact at their organization. The 6CS survey contained 16 preliminary questions that were used to collect administrators' opinions about the overall implementation of the 6CS framework and some

<sup>37</sup> Retrieved from the Internet on March 22, 2015 from:

[http://www.nasmhpd.org/Meetings/presentations/TransformationalLeadership/y\\_HuckshornFactSheet.pdf](http://www.nasmhpd.org/Meetings/presentations/TransformationalLeadership/y_HuckshornFactSheet.pdf)

<sup>38</sup> Centers for Medicare and Medicaid Services. Retrieved from Internet on April 9, 2015 from

<http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/downloads/SCLetter07-22.pdf>

<sup>39</sup> Retrieved from Internet on March 15, 2015 from:

[http://texreg.sos.state.tx.us/public/readtac\\$ext.TacPage?sl=R&app=9&p\\_dir=&p\\_rloc=&p\\_floc=&p\\_ploc=&pg=1&p\\_tac=&ti=40&pt=19&ch=748&rl=43](http://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_floc=&p_ploc=&pg=1&p_tac=&ti=40&pt=19&ch=748&rl=43)

contextual information. While at least one administrator from every site completed the survey, not all provided responses to the preliminary questions. This response rate was 75 percent.

## **Contextual Information about Participating Residential Treatment Centers**

### *Urban and Rural Sites Participated*

Geographic distribution of the 11 intensive sites varies between urban (Austin and Dallas) and rural locations for the all other sites. Some sites are more remote and further from city centers (Woodville, Ingram, and Boerne) than other rural sites (Glenn Heights, Lubbock, Liberty Hill, and Levelland). The average capacity of the intensive sites is 49.5 youth. Each RTC's individual capacity ranges from a minimum of 20 to a maximum of 134 youth.

### *Most Sites Had Tenured Leadership*

Of the administrators that completed the 6CS survey, their tenure at their respective RTCs ranged from 3 months to 31 years. The average tenure was 8.3 years and that indicates most of the RTCs have had stable and experienced leadership. Most of the intensive RTC sites specialized in the treatment of certain populations. They included youth with Autism spectrum disorders, county juvenile justice referrals, children younger than the age of 12, youth who have physical and intellectual disabilities, and gender-specific programs.

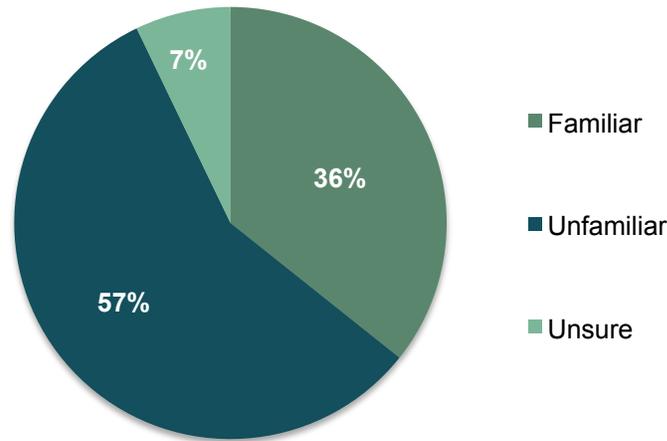
### *Motivation for Participations Varied*

Five of the intensive RTC sites identified their administrator or staff's attendance at a training/conference as the impetus for wanting to join the CCC initiative. Another, identified staff feedback as the reason and two RTCs cited that they were being closely watched by state regulators for their use of S/R as their motivation. Two intensive sites did not identify a catalyst. Finally, one site identified the initiative was part of their continuous quality improvement philosophy and they wanted to network and interact with other like-minded organizations.

### *Most RTC Leaders Already Familiar with the Six Core Strategies*

Of the administrators that completed the preliminary questions, more than half of the respondents identified they had previous exposure to the 6CS prior to joining the CCC initiative. Figure 17 shows that of the survey's respondents, almost 60 percent had previous exposure to the 6CS.

Figure 17: Residential Treatment Center Administration Prior Exposure with the Six Core Strategies®



### *Prior Familiarity with the Six Core Strategies Did Not Guarantee Success*

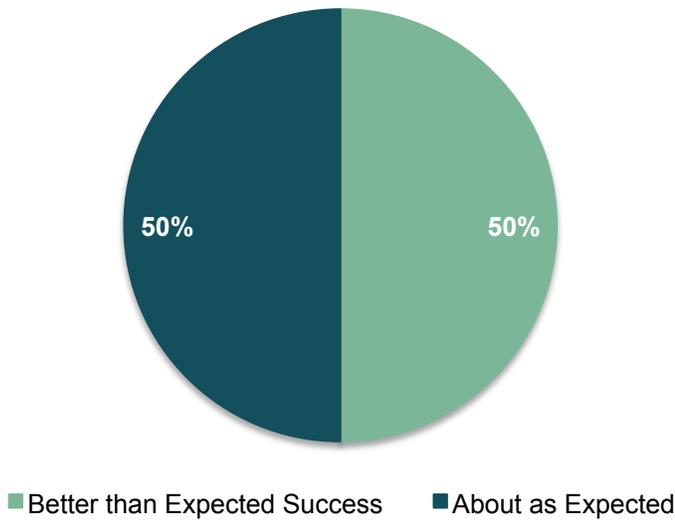
Familiarity with the 6CS did not necessarily correlate to successful implementation of it. Survey results show 3 of the 7 RTCs that self-identified they had “better than expected success” when implementing the 6CS and did not have experience with the 6CS before the initiative. Nor did familiarity with the 6CS correlate with achieving “better than expected success” at reducing S/R use. Three of the five sites that identified they were familiar with the 6CS before implementation did not experience a decrease in S/R use reported from 2011 to 2013.

### *RTC Administrators’ Expectations Varied About Implementation and Achieving Reductions*

Respondents indicated they had favorable expectations or at least realistic expectations about the how successful the 6CS implementation would be at their RTC. Figure 18 shows that of the survey’s respondents, half identified as having “better than expected success” and half identified as having about as much success as they expected regarding the 6CS implementation. Figure 19 shows 77 percent of RTC administrators self-rated their success at reducing S/R use as better than expected, while 8 percent rated it about as expected and 15 percent identified their implementation success as “worse than expected”.

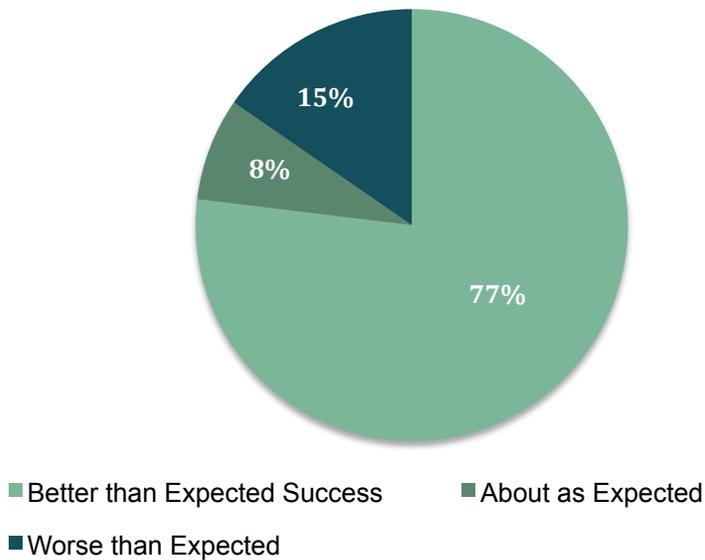
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**Figure 18: Residential Treatment Center Administration Self-Rating of Their Implementation of the the Six Core Strategies<sup>®</sup>**



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**Figure 19: Residential Treatment Center Self-Rating of Reducing the Use of Seclusions and Restraints with the Six Core Strategies<sup>®</sup>**



## Participating Residential Treatment Centers

The following organizations attended TNOYS's statewide training in January 2012 and immediately designed action plans to implement the Six Core Strategies:

### Autism Treatment Center, Inc.

Ownership: Non-Profit  
Funding Sources: State government, Private Pay, Donations  
Admin Tenure: 35 Years  
Age of Youth Served: 8 – 22 years old; Autism spectrum disorders

### Brookhaven Youth Ranch

Ownership: Non-Profit  
Funding Sources: State government  
Admin Tenure: 7 Years  
Age of Youth Served: 13 to 17 years old from county juvenile probation departments and the Texas Department of Family and Protective Services.

### Hill Country Youth Ranch

Ownership: Non-Profit  
Funding Sources: State government, Private Pay, Donations  
Admin Tenure: 9 Years  
Age of Youth Served: 5 – 18 years old  
Notes: Family style/relationship focused program

### Meridell Achievement Center

Ownership: Private  
Sources: Commercial, Private, Medicaid  
Admin Tenure: 18 Months  
Age of Youth Served: 5-17 years old; All patients have a history of treatment failure in inpatient and outpatient care. Patients are referred from throughout the USA and internationally.

### Roy Maas Youth Alternatives Meadowland

Ownership: Non-Profit  
Funding Sources: State government  
Admin Tenure: 20 Years  
Age of Youth Served: 6-17 years old; serves children who have been placed by DFPS, and/or probation

Sinclair Children's Center

Ownership:

Non-Profit

Funding Sources:

State government

Admin Tenure:

5 Years

Age of Youth Served:

5-12 years old; boys and girls; serves boys and girls who have varied disabilities including intellectual disabilities, emotional disturbance, learning disabilities, histories of abuse or neglect and other health impairments.

The following RTCs join the CCC initiative after 2012:

**Athletes For Change**

Ownership: Non-Profit  
Funding Sources: State government, Private Pay, Donations  
Admin Tenure: 2 Years  
Age of Youth Served: for boys, 13-17 years old

**Children's Hope, Lubbock**

Ownership: Non-Profit  
Funding Sources: State government, Private Pay, Donations  
Admin Tenure: 18 Years  
Age of Youth Served: 5-17 years old; girls and boys

**Children's Hope, Washington**

Ownership: Non-Profit  
Funding Sources: State government, Donations  
Admin Tenure: 20 Years  
Age of Youth Served: 5 – 17 years old; girls only

**Children's Hope, West**

Ownership: Non-Profit  
Funding Sources: State government, Donations  
Admin Tenure: 15 Years  
Age of Youth Served: 5 – 17 years old; boys and girls

**Helping Hand Home for Children**

Ownership: Non-Profit  
Sources: State government, Donations, Private Pay, Post-Adoption  
Admin Tenure: 20 Years  
Age of Youth Served: 4-13 years old; Boys and Girls; who have a minimum IQ of 70; who are unable to thrive and remain safe in a home setting; admitted have a variety of diagnoses, including Depression, Bipolar Disorder, Adjustment Disorder, Dissociative Disorders, Oppositional Defiant Disorder, ADHD, Reactive Attachment Disorder, and Post Traumatic Stress Disorder