Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MHL011-398	A. BUILDING: _____ B. WING _____	06/06/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SOLSTICE EAST, LLC	530 UPPER FLAT CREEK ROAD WEAVERVILLE, NC 28787

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
V 000	INITIAL COMMENTS A complaint survey was completed on 6/6/22. The complaints were unsubstantiated (Intake #NC00188772 and NC00188776). A deficiency was cited. This facility is licensed for the following service category: 10A NCAC 27G .1300 Residential Treatment for Children or Adolescents. The survey sample consisted of audits of 1 former client.	V 000	The Governing Body of Solstice East has reviewed the Statement of Deficiencies provided to Solstice East on 6/9/2022 by the Division of Health Service Regulation and submits the following Plan of Correction for identified deficiencies. Submitted to DHSR on 06/18/2022. V537 - Training in Seclusion, Physical Restraint, and Isolation Time-Out: Facility failed to ensure staff demonstrated competency in restrictive interventions for 1 of 1 former staff	
V 537	27E .0108 Client Rights - Training in Sec Rest & ITO 10A NCAC 27E .0108 TRAINING IN SECLUSION, PHYSICAL RESTRAINT AND ISOLATION TIME-OUT (a) Seclusion, physical restraint and isolation time-out may be employed only by staff who have been trained and have demonstrated competence in the proper use of and alternatives to these procedures. Facilities shall ensure that staff authorized to employ and terminate these procedures are retrained and have demonstrated competence at least annually. (b) Prior to providing direct care to people with disabilities whose treatment/habilitation plan includes restrictive interventions, staff including service providers, employees, students or volunteers shall complete training in the use of seclusion, physical restraint and isolation time-out and shall not use these interventions until the training is completed and competence is demonstrated. (c) A pre-requisite for taking this training is demonstrating competence by completion of training in preventing, reducing and eliminating the need for restrictive interventions.	V 537	Solstice East's Governing Body reviewed Tag V537 and gave direction for the following corrections, prevention measures and ongoing monitoring to take place: **Correction:** • Employee was trained in CPI (Crisis Prevention and De-Escalation) by a qualified trainer on 12/09/21. Training included: Recognizing and Responding to Crisis and Escalations and Safe Physical Interventions • Employee was terminated on 3/1/22, for nine reasons, one of which being misuse of a therapeutic transfer, which was *inconsistent with the employee's* training on 12/09/21. • Return demonstration by witness completed on 3/10/22 and reviewed with Executive Director, Program Director, and Operations Director. Witness demonstration revealed inappropriate use of standing escort, inconsistent with employee's training.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

[signature], Executive Director — 6/17/22

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V 537	Continued From page 1 (d) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (e) Formal refresher training must be completed by each service provider periodically (minimum annually). (f) Content of the training that the service provider plans to employ must be approved by the Division of MH/DD/SAS pursuant to Paragraph (g) of this Rule. (g) Acceptable training programs shall include, but are not limited to, presentation of: (1) refresher information on alternatives to the use of restrictive interventions; (2) guidelines on when to intervene (understanding imminent danger to self and others); (3) emphasis on safety and respect for the rights and dignity of all persons involved (using concepts of least restrictive interventions and incremental steps in an intervention); (4) strategies for the safe implementation of restrictive interventions; (5) the use of emergency safety interventions which include continuous assessment and monitoring of the physical and psychological well-being of the client and the safe use of restraint throughout the duration of the restrictive intervention; (6) prohibited procedures; (7) debriefing strategies, including their importance and purpose; and (8) documentation methods/procedures. (h) Service providers shall maintain documentation of initial and refresher training for at least three years.	V 537	**Corrections continued:** • All Solstice East employees will continue to be recertified annually in accordance with policy #4.4 • In-Service: All Staff review of Solstice East's current Restrictive Intervention policy sections: General Procedures for Restrictive Interventions, and Unapproved Methods of Restraint. • In-Service: Crisis and De-Escalation training with emphasis on least restrictive alternatives, guidelines on when to intervene, and the escalation cycle outlining the steps to an intervention. • Training 2x's annually will include two videos: (1) Calming and De-Escalation Strategies; (2) Dr. Conte: How to De-Escalate Anyone. • Role-Plays and Post-Test • ACRC Conference: Program Director, Executive Director, and Clinical Director will be attending Relationships First: Committing to the Reduction and Elimination of Restraints on July 11th in Louisville KY, as well as the 66th annual Association of Children's Residential and Community Services Conference through July 14th. **Prevention and Monitoring: Next Page**	

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V 537	Continued From page 2 (1) Documentation shall include: (A) who participated in the training and the outcomes (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (i) Instructor Qualification and Training Requirements: (1) Trainers shall demonstrate competence by scoring 100% on testing in a training program aimed at preventing, reducing and eliminating the need for restrictive interventions. (2) Trainers shall demonstrate competence by scoring 100% on testing in a training program teaching the use of seclusion, physical restraint and isolation time-out. (3) Trainers shall demonstrate competence by scoring a passing grade on testing in an instructor training program. (4) The training shall be competency-based, include measurable learning objectives, measurable testing (written and by observation of behavior) on those objectives and measurable methods to determine passing or failing the course. (5) The content of the instructor training the service provider plans to employ shall be approved by the Division of MH/DD/SAS pursuant to Subparagraph (j)(6) of this Rule. (6) Acceptable instructor training programs shall include, but not be limited to, presentation of: (A) understanding the adult learner; (B) methods for teaching content of the course; (C) evaluation of trainee performance; and (D) documentation procedures. (7) Trainers shall be retrained at least	V 537	**Prevention and Monitoring:** Beginning 6/21/21, the compliance, "stand-up" committee will review and monitor restrictive and behavioral interventions weekly to assess for appropriate application of de-escalation, least restrictive alternatives, appropriate application of support plans and restrictive interventions. Observations and emphasis will be focused on the safety and respect for the rights and dignity of all persons involved. The Stand-Up Committee consists of the following individuals: Executive Director, Clinical Director, Program Director, Nursing, Compliance Auditor, and the Operations Director. Weekly audits will continue for 60-days, or up until substantial compliance is demonstrated, and/or as directed by the Governing Body. Documentation will be indicated in weekly "stand-up" meeting notes and will be signed by the Executive Director. Records of completed In-Service Trainings will be reviewed and signed by the Executive Director on or before July 29, 2022. The Compliance and Quality Assurance Committee (CQAC) will continue to meet quarterly to assess trends and make recommendations for improvement(s). Continued, next page...	

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V 537	Continued From page 3 annually and demonstrate competence in the use of seclusion, physical restraint and isolation time-out, as specified in Paragraph (a) of this Rule. (8) Trainers shall be currently trained in CPR. (9) Trainers shall have coached experience in teaching the use of restrictive interventions at least two times with a positive review by the coach. (10) Trainers shall teach a program on the use of restrictive interventions at least once annually. (11) Trainers shall complete a refresher instructor training at least every two years. (k) Service providers shall maintain documentation of initial and refresher instructor training for at least three years. (1) Documentation shall include: (A) who participated in the training and the outcome (pass/fail); (B) when and where they attended; and (C) instructor's name. (2) The Division of MH/DD/SAS may review/request this documentation at any time. (l) Qualifications of Coaches: (1) Coaches shall meet all preparation requirements as a trainer. (2) Coaches shall teach at least three times, the course which is being coached. (3) Coaches shall demonstrate competence by completion of coaching or train-the-trainer instruction. (m) Documentation shall be the same preparation as for trainers.	V 537	**Prevention and Monitoring Continued:** If deficiencies are noted in the above audits, the following action plans will be implemented until substantial compliance is achieved as determined by the Governing Body: 1. Performance evaluations of staff 2. Identified and continued training of staff 3. Documentation of in-services provided or plan for improvement Auditing will continue per above plans until substantial compliance is met and maintained as directed by the Governing Body.	

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V 537	Continued From page 4 This Rule is not met as evidenced by: Based on record review and interview, the facility failed to ensure staff demonstrated competency in restrictive interventions for 1 of 1 former staff (FS) #1. The findings are: Review on 5/19/22 of FS #1's personnel file revealed: -Hired 12/6/21 as a Mentor. -Crisis Prevention Intervention (CPI) training completed 12/9/21. Review on 5/19/22 of the facility's Investigation Report signed by the Clinical Director on 4/29/22 revealed: -Date facility became aware of incident 4/26/22. -Date of alleged incident 2/26/22. -Former Client (FC) #1 alleged FS #1 "...touched her boob while in a therapeutic hold with staff." -Corrective Actions: FS #1 was terminated "...on 3/1/22 for nine noted reasons, one of which being moving resident by picking them up. This was a misuse of a therapeutic transfer and inconsistent with employee's training." Review on 5/19/22 of a Shift Change Note by FS #2 dated 2/26/22 regarding FC #1 revealed: -"Critical Information [FS #1] was tagged into [FC #1] and she went on the computer. After ignoring his requests to get off the computer, he attempted to guide her away from the computer. When she didn't budge, he (FS #1) wrapped his arms around her (FC #1) and physically picked her up and moved her away from the computer...." Attempted phone interview on 5/24/22 and 6/2/22 with FS #1. He did not return the message.	V 537		

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V 537	Continued From page 5 Interview on 5/24/22 with FC #1's guardians revealed: -The client said she was thrown on the floor. -She was in another facility currently and declined surveyor interview as the client was trying to move forward. Interview on 5/24/22 with FS #2 revealed: -She worked with FS #1 on 2/26/22 and witnessed the incident. -FC #1 was trying to use the computer and wasn't supposed to and FS #1 asked the client to get off the computer. -She saw FS #1 come up behind the chair FC #1 was sitting in, wrapped his arms around her waist area from behind and physically picked up the client, and removed her from the chair. -The client was still standing once removed from the chair and attempted to get back to the computer. -FS #1 held both her arms, in the forearm area, to keep her from getting to the computer.	V 537		

Solstice East Policy # 4.4	Title: Restrictive Interventions
Effective Date: 01/01/2013	Date Reviewed: 12/07/2020; 10/13/2021
Next Review Date: 12/01/2023	Record of Changes: (1) *Updated to reflect State rules on 12/07/21 (2) Re-Focus assessed on 10/18/21. Re-focus/Isolation specific rooms barred from use at SE.*

At Solstice East, Restrictive Interventions may be employed in emergency situations in order to terminate a behavior or action in which a resident is in imminent danger of abuse or injury to self or other persons or when property damage is occurring that poses imminent risk of danger of injury or harm to self or others.

After emergency usage of Restrictive Interventions have occurred, the therapist may determine that it is necessary to incorporate these interventions into the resident's Master Treatment Plan as a planned measure of therapeutic treatment.

Definition of Restrictive Interventions:

Physical Restraint ***(known as Brief Therapeutic Hold or Sustained Therapeutic Hold)*** – any time the use of physical interventions as outlined in the non-violent crisis intervention (CPI) training is employed.

Isolation Timeout ***(known as Brief Re-Focus or Sustained Re-Focus)*** – any time a resident is removed from the milieu for a period of 30 minutes or more in a separate location where exit is barred by staff but not locked and where there is continuous supervision by staff.

No rooms should be solely designated as Isolation or Re-Focus rooms at Solstice East. Assisting students in regulation and de-escalation is a collaborative process. Staff should refer to a student's crisis plan in their handbook or discuss the individualized treatment plan objectives with the student's therapist and treatment team. De-escalation strategies should be utilized to assist students that are experiencing distress. Training is provided to all staff members.

General procedures for Restrictive Interventions:

1. Restrictive Interventions should only be used as a last resort.
2. Shall not be employed as a means of coercion, punishment, or retaliation by staff or for the convenience of staff or due to inadequacy of staffing.
3. Shall not be used in a manner that causes harm or abuse.
4. Shall be carried out in safe and respectful ways.
5. Are employed after the use of positive and less restrictive alternatives have been considered and attempted (with the exception of emergency situations of imminent danger).
6. Consideration is given to resident's rights, dignity, and physical and psychological well-being before, during, and after use of restrictive interventions.
7. Only staff who have been trained in current Solstice East procedures concerning Restrictive Interventions may carry out the intervention.
8. When a restraint is used, staff both trained in CPR and CPI are physically present for continuous assessment and monitoring of the physical and psychological well-being of the resident and the safe use of the therapeutic restraint throughout the duration of said restraint. Staff both trained in CPR and CPI will remain with the resident for continued monitoring for a minimum of 30 minutes following the completion of a therapeutic restraint.
9. Observation and attention to client safety, physical, emotional, mental, and dietary needs should be documented in the resident record and observation log.

Staff responsible for the continuous monitoring of a resident will not have any other immediate responsibilities other than to monitor the resident for safety. Observations will be documented in the resident's chart.

Emergency Use of Restrictive Interventions:

1. A Restrictive Intervention is considered an emergency use if it is the first time such an intervention is used for the resident and/or when the use of a planned restrictive intervention is not part of the resident's Master Treatment Plan.
2. Restrictive Interventions that **do not** require authorization from a Qualified Professional but **should** be documented in the resident's shift note, in a critical incident note on the resident's chart and in an incident report:
   a. **Escort** (NOTE: escorting a resident while the resident is still voluntarily walking is not considered a Restrictive Intervention)
   b. **Brief Therapeutic Hold (15 minutes or less)**
   c. **Brief Re-Focus (up to 45 minutes)**
3. Restrictive Interventions that **do** require authorization from a Qualified Professional and **should** be documented on an observation log, in the resident's shift note, in a critical incident (crisis intervention) note in the resident's chart and in an incident report:
   a. **Sustained Therapeutic Hold (more than 15 minutes)**
   b. **Sustained Re-Focus (more than 45 minutes)**
4. Procedures for Sustained Hold or Sustained Re-Focus:
   a. Must be authorized in writing by a qualified professional (QP) after visual assessment with continued visual authorization in writing provided every 2 hours for the first 24 hours.
   b. If visual assessment is not possible initially, verbal authorization is permitted for the first 3 hours. After the first 3 hours, visual assessment and continued authorization must be provided every 2 hours.
   c. A record of continued authorization of a restrictive intervention must be kept on an observation log completed by the qualified professional if visual authorization is provided, or by person designated by qualified professional if authorization is verbal.
   d. Authorization for sustained emergency interventions may not exceed 24 hours. If exceeding 24 hours, written authorization must be obtained from the Clinical Director and the Executive Director, or designee.
5. The use of Restrictive Interventions will be discontinued immediately if/when:
   a. Imminent danger to self and others has ceased.
   b. Student is no longer experiencing a crisis and extreme distress; and is demonstrating emotional safety and regulation.

Debriefing of Restrictive Interventions:

1. After a therapeutic hold or Re-Focus has been used, the appropriate staff involved should hold a debriefing with the resident involved. This debrief should be documented on the incident report.
2. An incident report form must be filled out for each therapeutic hold or Re-Focus, and when a therapeutic hold is used, the staff who participated should engage in a debriefing with their supervisor. When completing incident reports for Restrictive Interventions, each instance of a therapeutic hold or Re-Focus should be documented with separate start/stop times noted.
3. Notes taken at any staff debriefing should be uploaded to the Incident Report system.

Documentation Required for Restrictive Interventions:

Whenever a restrictive intervention is utilized, documentation shall be made to include, at a minimum:

1. Statement regarding the client's physical and psychological well-being;
2. Notation of the frequency, intensity and duration of the behavior which led to the intervention, and any precipitating circumstance contributing to the onset of the behavior;
3. Rationale for the use of the intervention, the positive or less restrictive interventions considered and used and the inadequacy of less restrictive intervention techniques that were used;
4. Description of the intervention and the date, time and duration of its use;
5. Description of accompanying positive methods of intervention;
6. Description of the debriefing and planning with the client and the legally responsible person, if applicable, for the emergency use of physical restraint or isolation timeout to eliminate or reduce the probability of the future use of restrictive interventions;
7. Description of the debriefing and planning with the client and the legally responsible person, if applicable, for the planned use of seclusion, physical restraint or isolation time-out, if determined to be clinically necessary; and
8. Signature and title of the facility employee who initiated, and of the employee who further authorized, the use of the intervention.

Notification of Restrictive Interventions:

1. In the case of a restrictive intervention, parents/guardians should be notified as soon as reasonably possible unless specific requests have been made by these parties stating otherwise. The intervention should be reviewed with the parent/guardian and documented in the incident report.
2. The resident's treatment team and members of the governing body must be notified within 24 hours of the next working day and these parties will review the incident report.
3. Nursing should be notified as needed if possible injuries have occurred.

Restrictive Interventions as planned interventions in Master Treatment Plan:

1. A Therapeutic Hold (any) or Re-Focus (lasting more than 30 minutes) will be reviewed for inclusion into the MTP following the 2nd incident of emergency use.
2. A Therapeutic Hold or Re-Focus will become a planned intervention and be added to the MTP if emergency use is employed more than 4 times or more than 40 hours in a calendar month, or if any incident of emergency use of Re-Focus lasts longer than 24 consecutive hours.
3. Restrictive Interventions may be included in the MTP as a measure of therapeutic treatment designed to reduce dangerous, aggressive, self-injurious or undesirable behaviors to a level which will allow the use of less restrictive treatment.
4. All planned interventions must be documented in MTP prior to initiation or continuation of the restrictive interventions.
5. Interventions shall be based on clear and recent behavioral evidence that the intervention is having a positive impact and continues to be needed. Planned interventions in MTP discontinue after 6 months.
6. Prior to the initiation or continued use of a planned intervention, the following written notifications, consents and approvals shall be obtained and documented in the resident record:
   a. approval of the plan by the responsible professional and the treatment team, if applicable, based on an assessment of the resident and a review of the documentation.

b. consent of the resident or legally responsible person, after participation in treatment planning and after the specific intervention and the reason for it have been explained.
c. notification of an advocate/resident rights representative that the specific intervention has been planned for the resident and the rationale for utilization of the intervention; and
d. physician approval, after an initial medical examination, when the plan includes a specific intervention with reasonably foreseeable physical consequences. In such cases, periodic planned monitoring by a physician shall be incorporated into the plan.
e. Within 30 days of initiation of the use of a planned intervention, the Intervention Advisory Committee, by majority vote, may recommend approval or disapproval of the plan or may abstain from making a recommendation;
f. within any time during the use of a planned intervention, if requested, the Intervention Advisory Committee shall be given the opportunity to review the treatment/habilitation plan;
g. if any of the persons or committees specified in this policy do not approve the initial use or continued use of a planned intervention, the intervention shall not be initiated or continued. Appeals regarding the resolution of any disagreement over the use of the planned intervention shall be handled in accordance with governing body policy.

Unapproved Methods of Restraint

1. Any force that causes undue pain to the resident such as hitting, kicking, slapping, biting, wrist locks, arm locks, any form of pain compliance methods or pushing or shoving.
2. Any force or threat of force that causes undue anxiety within a resident, such as swearing, yelling, verbal abuse of any kind, or the threatening of bodily harm.
3. Physical restraints are always body-to-body. Other restraining devices like straitjackets, tie downs, locked rooms, or sedatives, or other mechanical or chemical restraints are not approved for use at Solstice East.

Education and Training in Restrictive Interventions:

Solstice East trains employees on the appropriate use of Restrictive Interventions. Solstice East places special emphasis in training staff to prevent the use of such through appropriate alternative interventions.

Procedures:

1. Employees who typically would engage in therapeutic hold procedures (CPI) must certify in the approved methods of holding and restraining, and must re-certify annually.
2. Only an approved trainer conducts regular training for staff. Training on therapeutic holds is a regular part of this training.
3. Each new residential employee is trained in restrictive interventions, to include therapeutic holds and Re-Focus as part of the new hire procedures.

Solstice East educates residents and their families on any potential use of holds.

1. Included in the admissions paperwork is an explanation of Solstice East's general behavior management techniques, including therapeutic holds and Re-Focus.
2. Included in the resident manual is an explanation of Solstice East's general behavior management techniques, including therapeutic holds and Re-Focus.

Performance Improvement:

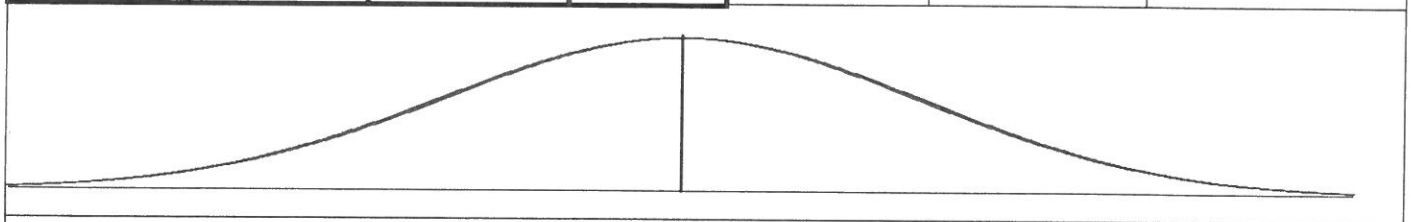
The performance, use, and trends of Restrictive Interventions are evaluated for improvement. The Governing Body aggregates data on the use of restrictive interventions at least every 3 months through the collection of Incident Reports, then measures and aggregates their appropriateness and effectiveness.

Escalation Cycle (adapted from Bounds, 2003)

**This is a tool teams can utilize to plan responses to each phase of the acting out cycle. This should be a part of a comprehensive positive behavior support plan.*

Specific Student Responses

Calm Cooperative	**Triggers** Unresolved conflicts	**Agitation** Unfocused	**Acceleration** Focused/intense	**Peak** Most severe	**De-escalation** Confused	**Recovery** Non-engage/alone



Specific Staff/Adult Response

Prevention	Prevention and redirection	Reduce anxiety	Safety	Crisis intervention	Remove excess attention	Re-establish routines

Adapted from Bounds (2003)

Lewis, Kittelman & Wilcox (2011).

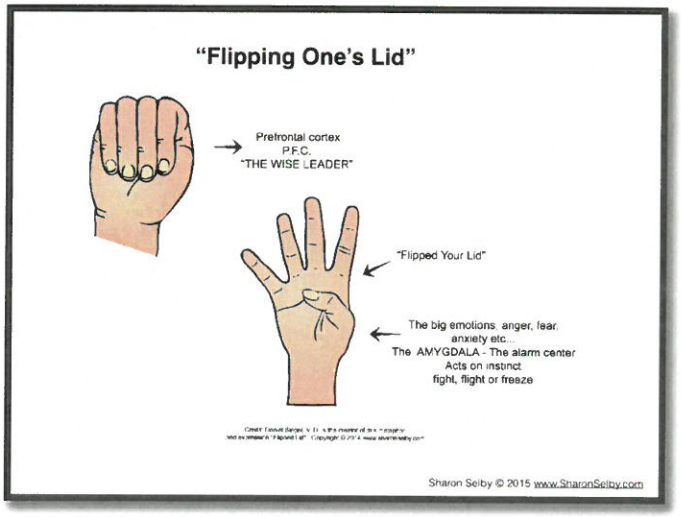
SOLSTICE
PROGRAMS

REGULATION Training

Regulation is the experience of being in control of our emotions and choices rather than our emotions controlling us. It means we are able to access greater levels of insight and control around our thoughts, feelings, physical experience, intensity, and responses. Regulation is to respond rather than react.

Regulation is the first skill our residents will need to develop in order to move forward successfully in their therapeutic journey. When we are not regulated, we are not able to process or integrate our experience.

Think of your brain like the hand model pictured below. All of our higher cognitive functioning is located in the pre-frontal cortex. This part of the brain is represented by the fingers when they are closed down over the thumb. In this model, we are able to access high level thinking, deductive reasoning, and problem solving. Our instinctual or survival mechanisms are located in the hind brain which is represented by the thumb when the fingers are lifted. In this model, we are not able to access our higher functioning cognitive skills and are reacting emotionally from our instincts for survival. This is sometimes referred to as "flipping your lid" and is the experience of someone who is not regulated. Regulation skills aid us in regaining access to our prefrontal cortex and moving us out of our hind brain and survival response.



Because our typical resident is one with a history of trauma, our typical resident is also one who spends much of their time in their survival brain (fight, flight, freeze, or fawn). They have adopted unhealthy coping skills to avoid, numb, displace, or control this experience through substance abuse, self-harm, technology addiction, eating disorders, unhealthy attachments etc. When our residents first arrive at Solstice, they have limited access or no access to these unhealthy coping skills. Therefore, they may be experiencing their emotions intensely without the skills to identify or tolerate them. It is our first goal to aid them in replacing these unhealthy coping skills with healthy regulation skills. This experience leads to distress tolerance and resiliency to challenging emotions.

It is important to note that regulation is not about being calm. It is about awareness and control. Regulation is not about the absence of difficult emotions like anger and sadness. These emotions are an appropriate response to certain experiences and can provide valuable information. Dysregulation is when these emotions last longer than is reasonably appropriate or begin to control our behavior and choices.

Dysregulation may also look different across individuals. For some it may be hyperarousal and look like outbursts of emotion or behavior while others may be hypoarousal and look more shut down or dissociate. Depending on the type of dysregulation, different coping skills may be more effective than others. The more closely you get to know the individuals you are working with, the more accurately you will be able to recognize when they are not regulated and what skills will be more supportive.

What is our Role?

- **Remain aware of our own need for regulation** and attending to that when necessary. The residents will directly mirror us as the keepers of safety and structure. If we are dysregulated, the residents will respond to our dysregulation.
- **Practice attunement** – remain in touch with the energy levels of individuals as well as the team as a whole. If the energy begins to feel out of control or is increasing in intensity beyond what is appropriate for the space or activity, take a moment to focus on regulation and regaining control of the environment
- **Validation** – the resident's experience, regardless of whether it is rational or not, is the honest experience of the resident. Validate their experience and work with them from that place, not where you believe they should be able to see things from.

If Jane is unreasonably angry because she thinks someone was talking negatively behind her back, her anger is real whether or not her belief is true. Work first with her anger. She will not be able to think critically about the situation until her emotions are regulated. We do not have to agree that her anger is justified, just that her anger is real for her.

- **Non-Judgmental** – we must always foster a safe environment for resident's to experience and learn to navigate their emotions. Approaching the messiness of this process without judgment is critical.
- **Respond with the pressure continuum** – we recognize that dysregulation is resistance and we respond to resistance by maintaining pressure (expectation). The resident is not able to tolerate the amount of pressure they are experiencing and are therefore becoming dysregulated. We maintain the expectation and focus on regulation skills.
- **Briefing the shift with residents and preparing for transitions** – preparing the residents for what to expect allows for predictability and structure which decreases confusion and chaos and helps to decrease dysregulation. This is why you will see fewer behaviors during highly structured times in the daily schedule compared to when there is less structure and more down time.
- **Co-regulation as a teaching moment and relationship building opportunity** – residents do not typically come to our program with healthy regulation skills, they must be taught first. Teaching residents these skills and co-regulating with them allows for them to experience regulation through their relationship with us, creating a positive attachment.

Tools for Regulation:

1. Mindfulness/Awareness

The first step to recognizing dysregulation is the ability to be attuned to and check in with ourselves. Do you know what your own dysregulation "tells" are? Do you act impulsively? Are you short-tempered or more argumentative? Do you shut down? Being familiar with our "tells" allows us to bring awareness to our behavior and what it is signifying.

Mindfulness is the thread that leads through all the steps of regulation; we must keep coming back to the practice of mindfulness and awareness. First we practice being aware of our thoughts and our body, this can look like curiosity about what we notice. Then we practice being able to detach from our thoughts; seeing them as separate from

us. Next we develop the ability to sit with our thoughts and to tolerate this experience. Finally, we develop the ability to gain some control over our thoughts (emotion regulation) and our body (physical regulation).

2. Physical Regulation Tools

Physical regulation tools are about our physical state of being. When our survival response is activated, we experience physical changes in our body as a result. This might include increased heart rate, blood pressure, and an increase in cortisol levels. Cortisol is the stress hormone activated in survival responses (fight, flight, freeze, fawn). The biological purpose of these physical changes is to prepare us for our survival response. However, a person with trauma may experience a survival response when there is no threat present.

It is helpful to remember the "flipping the lid" model when thinking about physical dysregulation. When our lid is flipped, we are stuck in our hind brain and functioning from a need for survival. Physical regulation tools help to bring our body into a more regulated state as well as move us out of our survival brain.

Here are a few physical regulation skills to get you started:

1. Breathing

Skills involving deep breathing or controlled breathing are proven to directly impact our physiological state without the need for us to access higher level cognition. These skills lower cortisol levels, blood pressure, and heart rate.

i. ***Deep breathing*** – with pressured release
ii. ***4 square breathing*** – breathing for a count of 4, hold for 4, breathe out for 4, hold for 4, repeat.
iii. ***4-7-8 breathing*** – breathe in for a count of 4, hold for 7, breathe out for 8 (especially good for difficulty sleeping)
iv. ***Alternate nostril breathing*** – breathing in and out of one nostril at a time

2. Bilateral Stimulation

Bilateral stimulation calms the two hemispheres of the brain allowing them to communicate more effectively and, therefore, moving us out of our hind brain and survival response. It simply refers to any movements that cross our horizontal hemisphere and engage both sides of the body one at a time.

i. **Pretzel** – this tool is used in trauma informed hospitals and has been known to stop panic attacks on the spot. Cross your right arm over your left with palms turned in towards each other. Clasp your hands and draw them in to your body like a pretzel. Cross your right foot over your left at the ankle. Hold this pose for 2 minutes while breathing deeply. This stimulates the parasympathetic nervous system and contributes to a physically regulated state. **If this pose is too activating, try bilateral tapping.
ii. **Bilateral tapping** – sitting down, you can cross your arms to lay opposite hand on opposite knee. Gently tap your right hand on your left knee, then left hand on right knee and continue to repeat that pattern.
iii. **Restorative movement** – crossing the midline (imagine a line separating your body in two from head to toe). This could look like standing up and repetitively crossing my right elbow to my left knee, left elbow to right knee.

3. Rhythm

Because trauma can be stored in the body, it can be helpful to use "patterned, repetitive, rhythmic activity" to regulate what we may not be consciously aware of. Responses to trauma can be non-verbal or subconscious and can be stored in our nervous system throughout our body. Rhythm helps to soothe the nervous system when it is activated. Some examples of rhythmic tools are rocking, knitting, hula-hooping, swinging, jump roping, jogging, bouncing, spinning poi, etc.

3. Emotion Regulation Tools

Physical regulation tools help us to move out of our hind brain into our prefrontal cortex. It brings us into a physically regulated state which in turn prepares us for emotion regulation.

Emotion regulation leads to distress tolerance; learning how to get through negative, uncomfortable situations without making it worse

Some examples of emotion regulation are:

i. Improve the moment – finding the positive/meaning, relax, take a break. How can you make this present moment better.
ii. Distraction – shift focus from upsetting thoughts to more enjoyable or neutral activities. Compartmentalize; this may not be the appropriate time

iii. Self Soothe – the ability to be comforting and nurturing to yourself.
    - Heart hug – crossing hands over your chest with your right hand in your left armpit and your left hand on your right shoulder, squeeze in and down. This stimulates the Ventral Vagal nerve which brings about feelings of safety, connection, and containment
    - Progressive muscle relaxation – laying on the ground, slowly tense each muscle group and release starting at your feet to the top of your head. At the end, tense all the muscles in your body and release. Helps with relaxation
    - Resourcing – remembering a positive memory or looking at photo of loved ones and accessing the emotions associated with that resource.
    - Self Care – using the 5 senses, what is soothing to the senses; touch (rub a soft pillow), smell (essential oil), sight (sunlight through the trees), hearing (running water), taste (yummy food)

4. Processing Tools

Processing our experience or emotions is not effective unless we are both physically and emotionally regulated. The following tools are helpful in sorting through our experience and emotions in a regulated way before we move forward with decision making:

i. Wise Mind vs. Emotion Mind vs. Rational Mind – Wise mind is the balanced, regulated place between emotion mind and rational mind. Emotion mind doesn't take into consideration much reasoning and is only concerned with the emotions. Rational mind is detached from emotions that may be involved in a situation. Wise mind is able to take both into consideration to reach a common ground in the middle.
ii. Belief of self, communication with self – processing the dialogue we have internally and bringing more awareness to that dialogue
    - Nuts and challenges
    - Behavior chain analysis
    - Awareness wheel
iii. Communication of self to others- part of processing our experience can come from sharing our experience with others. Using "I feel" statements is a tool to practice communicating our internal experience with the external world. See "I feel" statements in the appendix.

5. Decision-Making Tools

Once physically, emotionally, and behaviorally regulated, we can make decisions that are in our best long-term interest. This is where are major decision-making should come from. Here are some tools when students are struggling to make difficult decisions:

i. Pros and Cons list – include pros and cons for all options on the table
ii. Play out the script – what would happen, how would it effect others, how would it effect yourself, etc?
iii. Full plate – when overwhelmed, analyzing what is on your plate and prioritizing what needs to be done first, what can be saved for later, what can come off or be delegated, etc.
iv. Gathering information – making sure we have all the information we need to make an informed decision
v. Checking in with our principles and values – are our decisions in line with them

** You can also find additional coping skills in the appendix of the student handbook.

CRISIS AND DE-ESCALATION

Crisis Recognition And Response

Crisis Intervention

A process to assist individuals in finding safe and productive outcomes to unsettling events

Importance of Time in the Crisis Communication Process

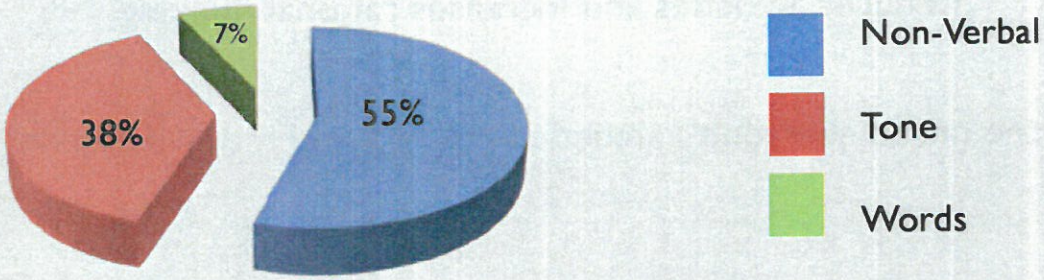
Time (passage of time) generally has a positive effect on crisis intervention

Reduces anxieties and Increases rational thinking

At the onset, everyone's anxieties are high and rational thinking is low.

3 Aspects of Communication

- Body language
- Tone
- Word Choice



"Voice" - Your #1 Tool

The WAY something is said can be 5x more important than What is said.

Tone of voice, demeanor & projected sincerity are more important than any single phrase that you may use.

Remember:

Calm is just as contagious as fear or panic

Things You Should Not Do When Interacting With Someone In Crisis

- Tell them to "snap out of it"
- Be sarcastic
- Problem solve
- Make light of their experiences
- Blame
- Dismiss their feelings
- Treat someone with mental illness as unintelligent
- Expect rapport to develop quickly
- Trivialize their problems
- Argue moral issues

Calming and de-escalation strategies
https://www.youtube.com/watch?v=R2PSExM-NhU

Dr. Christian Conte: How to de-escalate someone
https://www.youtube.com/watch?v=4qsfBCatgX8&list=RDCMUC47w9g7IESxzqefb5vWkN1Q&start_radio=1&rv=4qsfBCatgX8&t=4

Using De escalation Skills in a Healthcare Setting
https://www.youtube.com/watch?v=Q4T-x1za6Ig

TIPS

Screaming – Remember this: "Low and Slow". Keep your voice low and slow,
you can help them to regulate by regulating yourself.
Resist the urge to talk louder so they can hear you.
Do not sit or stand too close, give them some space.
Let them know if you need even more space to keep yourself regulated.
"I am going to move over here to give us some space. I will be right here if you need help."

TIPS

by Margo Murphy LCMHC-A

Shut down – Same thing: "Low and Slow". Resist the urge to "get them out of it". Sit near them. Let them know you are there. You can ask if ice, a cold stone, essential oils would be helpful. At times, silently offering an object, like a stick to peel, or a fidget helps to soothe (sensory).

TIPS

by Margo Murphy, LCMHC-A and Danielle Andrews, LCMHC, CFTP

Dysregulation (acting out) – focus on your own deep breathing and stay CALM. Say what you are noticing by **Reflecting and Validating** their emotion without judgement or fear. "that sounds frustrating; I see that it makes you angry" PAUSE for them to keep processing. As staff, take some deep breathes (they may unconsciously coregulate with you).

Try this approach (EFFT): **You feel "x", because ____, because ____, because____**
Let them share more and get it out (you may have asked them to go for a walk or grab a snack with you in the kitchen by this point – casual and calm). Repeat this step two more times. You feel "x" because ___, because ___, because ___. Pause and repeat.

MINIMIZE WORDS – Remember, when perceiving a threat, the blood and oxygen move to the hands and feet. Logic goes out the window and you cannot access reason until regulated.

TIPS

- It is your job to be with them, not to take away their pain.
- SLOW YOURSELF DOWN, attune to what the kiddo is telling you through their behavior.
- There is not one right way to handle any situation, go with your gut.
- Put yourself in their shoes.
- What might your young self have needed when regressed and feeling these emotions
- Maintain confidence, clarity, compassion, and calm, and consistency (the C's)

TIPS

When a kiddo expresses feeling unsafe, ALWAYS get curious about this. Even if it seems obvious that they are joking, what's underneath that? If you hear something, say something. Even if you just say, "Hey, I just heard you say _____, what did you mean by that?" If other kiddos were around and heard them say it, check in with them too." Hey, I know you just heard your peer say _____ I wanted to see how that landed with you."

- This is incredibly important. You might avoid a situation where one or more become dysregulated and act out simply by getting curious ahead of time. Slow yourself down whenever you think of it so you can be in a space to notice shifts in the kiddos (and your co-staff!) around you.

TIPS

Try to avoid an audience whenever possible. If that means moving the other students, find a way to do that. Or, see if the struggling student is willing to try a change of scenery.

Remember: When in flight, flight, freeze, you cannot access logic. The ability to choose from options or state a need is not typically possible!! You need to be more directive. "Lets go to the kitchen and grab some juice or a snack; I want to hear what you have to say." "I've peeled an orange for you". If they don't eat the orange, have them smell it (sensory).

ONLY GIVE SAFE OPTIONS – If you are giving a kiddo options (when regulated), every option needs to be a safe one. This helps them to feel empowered while also staying safe. "You can move to the common area. We can go on a walk (if run risk is not applicable and it is not dark outside). We can go make some tea. Which option sounds like something you would be willing to do?"

HUGE THANK YOU TO ALL OF OUR STAFF.

YOU MATTER! WHAT YOU DO MATTERS.

Pre-Conference

Monday, July 11
1:30-4:30pm

ACRC Presents

Relationships First: Committing to the Reduction and Elimination of Restraints

Omni Hotel in Louisville, KY

Our increased understanding of trauma and brain science is leading the field to rethink restraint and seclusion, equipping staff instead with effective relational strategies. This organizational transformation often begins with leadership initiating a shift in knowledge, beliefs, and culture. Spend the afternoon with several ACRC member organizations who have made this commitment and will candidly share their journey toward excellence. *ACRC will provide a platform for continuing the conversation beyond this afternoon as we invite these preconference attendees to monthly roundtable conversations focused on our individual and collective successes and challenges.*

Recipe for Success

Over the past 8 years The Barry Robinson Center has gone from averaging over 100 restraints a month to less than 1 per month. Clinical outcomes have improved, staff turnover has decreased, and workers compensation has decreased. The recipe is not a secret.

Presenter: **Robert E. McCartney, MSW, *CEO, The Barry Robinson Center***

Can Restraint Reduction Exist Without Restraint Elimination

This presentation will describe our RTC's efforts to reduce physical restraints. Data collected during these efforts will be presented. We will also look at the struggle we have had between continuing restraint reduction efforts versus embracing a restraint elimination plan.

Presenters: **Denise Luft, LMHC, *Associate Executive Director, Quality Assurance*** & **Jordan Wood, MNA, *Director of Strategic Initiatives, Green Chimneys***

Using Data to Track Restraint Reduction

At Sycamores, we support safety in lieu of restraints. We are excited to highlight our data collection process, show our dashboards, and share how we use our data to make decisions and to ultimately understand how effective we are.

Presenters: **Joe Ford, *Chief Program Officer*** & **Nick Ryan, *Assistant Vice President of Training and Implementation Practice, Sycamores***

The Way it is: Restraint Free Residential Interventions

In 2012, YDI embarked on a quest for the 'Holy Grail' of restraint elimination. This 5-year journey led us to examine much more than our restraint policies and procedures, it was an introspective look at our how we hire and train our staff and how we authentically engage and understand the young people we serve.

Presenter: **Trish Cocoros, *Co-Executive Director, YDI***

Restraining Children and Youth: What the Research Tells Us

Drawing on the international research literature this Zoom presentation will explore the restraining of children and youth in residential treatment centers, group homes, and other residential facilities. Who is restrained, why are they restrained, what are the impacts of restraint, and how might restraint be reduced or eliminated?

Presenter: **Dr. Iain Matheson, *Director, Research Centre for Better Outcomes from Fostering and Residential Care, New Zealand***

Restraint Elimination Starts with YoU

This presentation will fully describe the journey of one behavioral healthcare provider with a restraint problem. Through an initiative to manage physically aggressive behavior safely without utilizing restraint, a problem became an invention (Ukeru) and an opportunity to assist other organizations. The lessons learned will be shared around keeping individuals AND employees safe while providing effective treatment/education AND financial responsibility.

Presenter: **Kim Sanders, *COO, Grafton Integrated Health Network and President, Ukeru Systems***

association of Children's Residential & Community services

Register at www.togetherthevoice.org/annual-conference