



CONNECTICUT JUVENILE TRAINING SCHOOL (CJTS) AND PUEBLO GIRLS PROGRAM

Action Plan Presentation
JJPOC
August 21, 2015



Order of Presentation:

- Clinical Services CJTS and Pueblo
- CJTS Youth
- Pueblo Girls Program
- Qualitative Process



CLINICAL SERVICES

CJTS and Pueblo Girls Program



Clinical Staff

- ▣ 15 Licensed Clinical Social Worker (Master level)
- ▣ 7 Licensed Clinical Psychologists (Ph.D. level)
- ▣ 3 Board Certified Child and Adolescent Psychiatrists



Purpose

- The Clinical Services Department helps to shape the environment and culture, work as a part of a multidisciplinary team and provide tools to the youth, their families and staff to:
 - reduce risk for re-offending;
 - address mental health needs; and
 - successfully reintegrate youth back to his/her family and community.



Expanded Role of the Clinician

- ▣ **Clinician will remain on site from 8:00 a.m. to 8:30 p.m. Monday through Friday and 9:00 a.m. to 5:30 p.m. Saturday and Sunday.**
- ▣ Continued on-call coverage where a clinician comes to the facility to conduct a face to face assessment during a crises after hours 8:30 p.m. to 8:00 a.m. Monday through Friday and 5:30 p.m. to 9:00 a.m. Saturday and Sunday.
- ▣ **Continued clinical presence during incidents of restraint. Clinician will ensure that the youth's behavioral support / intervention is being followed.**
- ▣ Clinician assistance with verbal de-escalation when youth are emotionally dysregulated and reinforce use of Dialectical Behavioral Therapy and other supports to develop coping skills.
- ▣ **Clinician determination of need for seclusion based upon the youth presenting as an imminent risk of harm to self or others.**



Clinical Services Provided

- ▢ Services provided include individual therapy, family therapy, group therapy, psychiatric evaluation, medication management, psychological testing, and crisis and safety assessments.
- ▢ Continued use of intake screening and assessment instruments.
- ▢ **Identification of additional mental health assessment tools (BASC-2 and CRPT) as a part of the JJPOC initiative.**
- ▢ Continued use of evidence based treatments to address mental health needs and juvenile delinquency needs (2003- ART, 2004- Seven Challenges, 2007 DBT, 2012- TF-CBT).
- ▢ Identification of new evidence based models (2016 - ITM, MRT) to enable front-line staff to support behavioral health interventions for youth, including promoting the use of coping skills.
- ▢ **Doubled coverage of psychiatrists to two full time equivalents in 2015. This allowed for a psychiatrist to be available to all youth from the time of intake to discharge. All boys will be seen by the intake unit psychiatrist during the first week and screened for any immediate psychiatric needs.**



Clinical Services Provided

- ▣ **All youth receive a psychosocial assessment. Assessment will be enhanced to include three parts: psychiatric summary, psychological testing summary and psychosocial/family summary.**
- ▣ **Improving the use of clinical information develop each youth's behavioral support/intervention plan with the goal of reducing restraint. Youth will participate in the development of these plans, and front line staff will be taught on the elements of the plan.**
- ▣ Clinical information and behavior plan is presented in multidisciplinary treatment team meetings and reviewed monthly.
- ▣ Ensure that discharge and aftercare planning and implementation is timely and effective.
- ▣ Transition youth back to their communities by using evidenced based in-home, wrap-around models (MST-FIT and MDFT-RAFT).
- ▣ Improved collaboration with regional DCF staff, community-based juvenile justice service providers.



Continued Improvement in Suicide Prevention Practices – Suicide Practice Consults /Audits

- Revised our suicide prevention policy in 2004 and modified the admission screening process to include a specific suicide measure (Suicide Ideation Questionnaire).
- Site consultation in 2006 with Lindsay Hayes, suicide expert.
- **American Correctional Association (ACA) audits in 2009 and 2012 of suicide prevention training curriculum, policy and individual youth records during three day on-site audits. The ACA standard was met during both audits.**
- Another ACA audit is scheduled for fall 2015.
- **UCONN suicide expert will conduct full audits on an annual basis and partial audits quarterly.**



Continued Improvement in Suicide Prevention Practices – Suicide Curriculum / Staff Training

- ▢ Trained all staff in 2004 on suicide prevention efforts as provided by Lindsay Hayes.
- ▢ Refresher training with post-test provided to all staff in 2009 and continued to the present.
- ▢ **Began training in a new evidence-based suicide prevention curriculum (Shield of Care) in 2013, which is now being provided to all staff. New hires receive 8 hours of training and other staff receive two-hour refresher training.**



Continued Improvement in Suicide Prevention Practices – Youth Suicide Assessments

- ▮ Since 2004, all youth who make any suicidal comments, engage in self-harm or any suicidal behavior are immediately placed on direct observation and the youth is assessed by a licensed clinician or psychologist.
- ▮ A clinician is either on site or on-call 24 hours to conduct a face-to-face safety assessment.
- ▮ A licensed psychiatrist is available on call during weekends and, during weekdays, sees any youth who is on a one-to-one. The psychiatrist will come in on the weekend when indicated.
- ▮ **Clinician safety assessments will be modified to include more specific details about youth suicide intent, imminent risk and protective factors, in addition to suicide behaviors and risk management plan.**
- ▮ Clinician will meet with youth on regular intervals while on safety watches to provide treatment in addition to safety assessment.
- ▮ **Institute a teaming review to include parent, guardian, regional staff, facility treatment team for youth who have 3 or more episodes of suicidal behavior and or restraint/seclusion in a month.**



Continued Improvement in Suicide Prevention Practices – Youth Suicide Assessments

- ▮ **Clinicians will participate in suicide debriefings to ensure that care plans/behavioral support plans are followed and to determine need for modification in plans.**
- ▮ The CJTS psychiatrist and clinical team has a working relationship with the psychiatrist at the local Middlesex Hospital Emergency Department, and youth with significant psychiatric needs are treated there as well.
- ▮ **The facility also collaborates when needed with Solnit South campus and the CT Behavioral Health Partnership/Value Options to hospitalize youth under age 18 requiring a higher level of care.**
- ▮ For youth 18 years of age and older, the facility collaborates with DMHAS Young Adult Services and has a monthly meeting with DCF and DMHAS staff to discuss youth identified as eligible for DMHAS services at age 18. Assistance from DMHAS is sought for youth who require hospitalization.



Trauma Informed Culture – Staff Training / Activities

- ▣ **Trauma experienced as a result of adverse childhood experiences must be addressed in order to effectively treat and rehabilitate youth and prepare them for successful re-integration to home, school and community.**
- ▣ Development of a trauma informed culture that permeates all aspects of life at the facility is crucial.
- ▣ Trauma expert Dr. Julian Ford from UCONN presentation to all staff in May 2005 emphasized key principles and skills. Addressing trauma goals were incorporated into individual treatment plans.
- ▣ Facility participated in monthly consultation in 2010 with the JRI Trauma Center to assess our capacity to address youth trauma. A multidisciplinary group participated and developed a work plan to improve policies, staff development, services, and youth involvement.



Trauma Informed Culture – Staff Training / Activities

- ▢ In 2012, CJTS staff “trauma champions” developed activities for staff to raise awareness of the need to address youth trauma as well as staff vicarious traumatization.
- ▢ **Staff training January 2015 by Eileen Russo, LSCW Trauma trainer from Women’s Consortium to recognize their personal trauma and its impact on their work with youth.**
- ▢ **Eileen Russo is scheduled to return August 20, 2015 1:00 – 3:00.**
- ▢ All staff initial and annual training to include working with youth with trauma, psychiatric disorders and other specific learning disabilities November 2015.
- ▢ **Encourage ongoing staff discussions of trauma and better ways to manage and interact with individual youth through trainings, group and individual supervisions, case review meetings, treatment team meetings, grand rounds and other venues with designated topics available to staff.**



Trauma Informed Culture – Youth Activities

- ▮ Implementation of trauma assessment tools from 2004 to present (TESI, UCLA-PTSD, TSCC/TSI-2).
- ▮ Continue to provide skills training in mindfulness and emotion regulation to all youth and trauma specific treatment to youth with significant trauma histories (DBT, TF-CBT).
- ▮ Explore implementation of evidence based model into the Cady school by October 2015.
- ▮ **Individual youth trauma triggers will be clearly identified in youth-specific behavioral support/intervention plans and reviewed in treatment teams with line staff September 2015.**
- ▮ **Development of Comfort rooms: 4D youngest boys relaxation room opened 2014; Girls program comfort room opened in August 2015, Boys Intake unit comfort room to be opened in Sept 2015, Boys general population units to have comfort room by October 2015.**
- ▮ **Administer the ACE (Adverse Childhood Experience) to identify trauma risk factors October 2015.**



Trauma Informed Culture – Facility Consultation

- ▣ **Technical assistance to CJTS management began August 2015.**
- ▣ Global trauma informed care review of evidenced based models August through November 2015.
- ▣ **Incorporate trauma informed principles into CJTS/Pueblo training, policy and practice guide October 2015.**
- ▣ **Collaborate with DCF core team to review clinical programming and develop cohesive trauma informed model (such as ARC model) with overarching principles that encompasses current evidenced based programming (DBT, Seven Challenges, ART) November 2015.**



REDUCTION OF RESTRAINTS AND SECLUSIONS

CJTS and Pueblo Girls Program



Reduction of Restraints

- ▮ Safe Crisis Management (approved Intervention curriculum) refreshers throughout the year and annual recertification with ongoing focus on theory and de-escalation methods and strategies to avoid restraints. The curriculum focuses on theory, de-escalation, trauma and specific holds to control youth escalation or crisis.
- ▮ **Prone restraints (face down) banned 7/23/15 all staff notified.**
- ▮ Prone holds (face down) removed from Safe Crisis Management training, Side Assist continues to be utilized as an alternative. This was an added technique/hold introduced in the Spring of 2014 to prepare for elimination of prone (face down).
- ▮ More enhanced Intervention plans for youth to assist as a preventative measure when they are in crisis. Youth to be involved in this process. Plan includes triggers, medical issues, restrictions.
- ▮ Continue to minimize use of mechanical restraints except for transporting a youth across campus or off campus. Authorization currently granted by Supervisors and Police Sergeant only who are the only ones who carry restraints on person.
- ▮ **Contacting a supervisor to report to the scene as soon as it's discovered a resident is beginning to escalate. 7/29/15 all staff notified.**
- ▮ Plans to incorporate comfort rooms for all units. Rooms identified with clinical working with managers to determine specific items for the room.



Reduction of Seclusions

- ▮ **Clinician will directly engage youth while in seclusion including the seclusion room when safety permits effective 9/1/15.**
- ▮ At start of seclusion confirm and document seclusion is necessary identifying if imminent harm to self or others is evident. Enhancement of current assessment process to include clinical as the point.
- ▮ No seclusion episode longer than 4 hours, clinical to assess to determine hospitalization referral is needed in consultation with Psychiatric team.
- ▮ **Release from seclusion immediately when a clinician determines that youth is not a danger to self or others.**
- ▮ Develop better techniques in dealing with disruptive youth (Training).



Daily Post Event Debriefing – Began on 8/10/2015

- Existing process of administrative review the following day for pre-screening.
- **Multi-Disciplinary approach and inclusion daily following pre-screen - Management, Clinical, Trainer, Medical, Residential, QA, and Education.**
- Meeting includes review of paperwork, videos and discussion from various disciplines.
- **Post Event Administrative Review report - to be initiated by Assistant Superintendent with sections being completed by managerial leads for each department.**
- More enhanced Post Event Learning forum with staff involved in events.



Out of Program Time

- To be modified to include more options to deal with disruptive youth including restorative justice, community service, and clinical based initiatives.



Enhanced Front Line Supervision

- ▣ **Enhanced presence and rounds during every shift.**
- ▣ Training plans in progress.
- ▣ Ongoing and annual review of staff expectations while on shift for all staff.
- ▣ Code of Conduct outlining expectations to staff has been disseminated.



PUEBLO GIRLS PROGRAM

Opened March 19, 2015



Staff Training Prior to Opening:

- “Understanding Girls: a Trauma Informed Perspective” – Teaching staff the role of trauma in the lives of the girls we serve and how to provide effective services that address trauma.
- Safe Crisis Management: Preventing the situations that necessitate restraint and seclusion.
 - Identifying and avoiding triggers
 - Alternative interventions that do not include restraint/seclusion
 - When staff should remove themselves from a situation
 - De-escalating behaviors
 - Importance of building strong relationships as the foundation for positive staff-youth relationship
- Human Trafficking
- Behavior motivation: How to encourage positive youth behavior
- Girls Circle: Girls special strengths and challenges relating to relationships, family and self-esteem



Staff Training Prior to Opening:

- ▣ Relational Aggression: Teaching staff to identify social relations and non-verbal cues that can trigger conflict
- ▣ Suicide Prevention (“Shield of Care”)
- ▣ Dialectical Behavior Therapy: teaching youth self-coping skills to prevent crises
- ▣ Mental Health/First Aid: how staff can care for themselves in their challenging work
- ▣ Seven Challenges: substance abuse treatment
- ▣ Family Engagement: training on the assessment and intervention with conflict family systems across generations.
- ▣ Gang Training
- ▣ Team building
- ▣ Security Protocols
- ▣ Tours of Journey house, Touchstone, Washington Street Secure Residential Program, and former GRACE non-secure residential program.



Six Core Strategies to Reduce the Use of Seclusion and Restraint

- ▣ Multi-disciplinary team of staff attended a two day training December 2014.
- ▣ All staff meeting February 2015 to begin discussing new strategies and enhance current practices to reduce the use of restraints and seclusions. Meeting included staff feedback on challenges and tools needed to support front-line staff.
- ▣ Prone restraint prohibited effective 7/23/15.
- ▣ Restraint and seclusion prevention trainers (“Safe Crisis Management”) effectively teach staff on the elimination of prone restraints in our training curriculum, including alternative techniques, and emphasis on prevention.



Restraint and Seclusions Have Reduced at Pueblo

- ▮ Training and professional judgement are used when a decision is made to utilize a physical intervention. Staff consider the imminent risk (**know the behavior is about to happen**), which includes knowing the youth they're working with, youth history, previous incidents at Pueblo and other programs, youth body language, and tone of voice.
- ▮ From December 2014 through July 2015, the program used 21 physical interventions. 11 of these were standing holds lasting less than two minutes and majority were two unique youth.
- ▮ From December 2014 through July 2015, the program used seclusion (locked, unlocked, or staff remaining in a room with a youth) 20 times for six unique youth. All were for safety reasons -- not for behavior management or program compliance. No seclusion was over four hours, in compliance with national best practice standards.
- ▮ We are cross referencing the Council of Juvenile Correctional Administrators Toolkit: Reducing the Use of Isolation. We will continue to use as a guide to enhance practices already in place.
- ▮ I can provide three specific examples of recent staff repair, and use of restraint seclusion. All three were very successful and interventions were least restrictive, standing holds, staff posted inside the rooms with the girls, doors unlocked, and successful staff/peer processing.



Comfort Room

- The development of the comfort room began January 2015.
- Youth participated with clinical staff to paint, decorate and pick out items that would be beneficial for self-soothing and enhancing coping skills.
- The comfort room was completed and opened for youth on 8/12/15.
- Data is being collected based on youth feedback regarding how they felt prior to entering the comfort room and when they exit.



Out of Program Status

- ▮ The programs are increasing the use of restorative tasks and staff/youth relationship repair work instead of sanction time.
- ▮ Community meetings are held weekly at Pueblo and youth feedback is strongly encouraged.



QUALITATIVE PROCESS

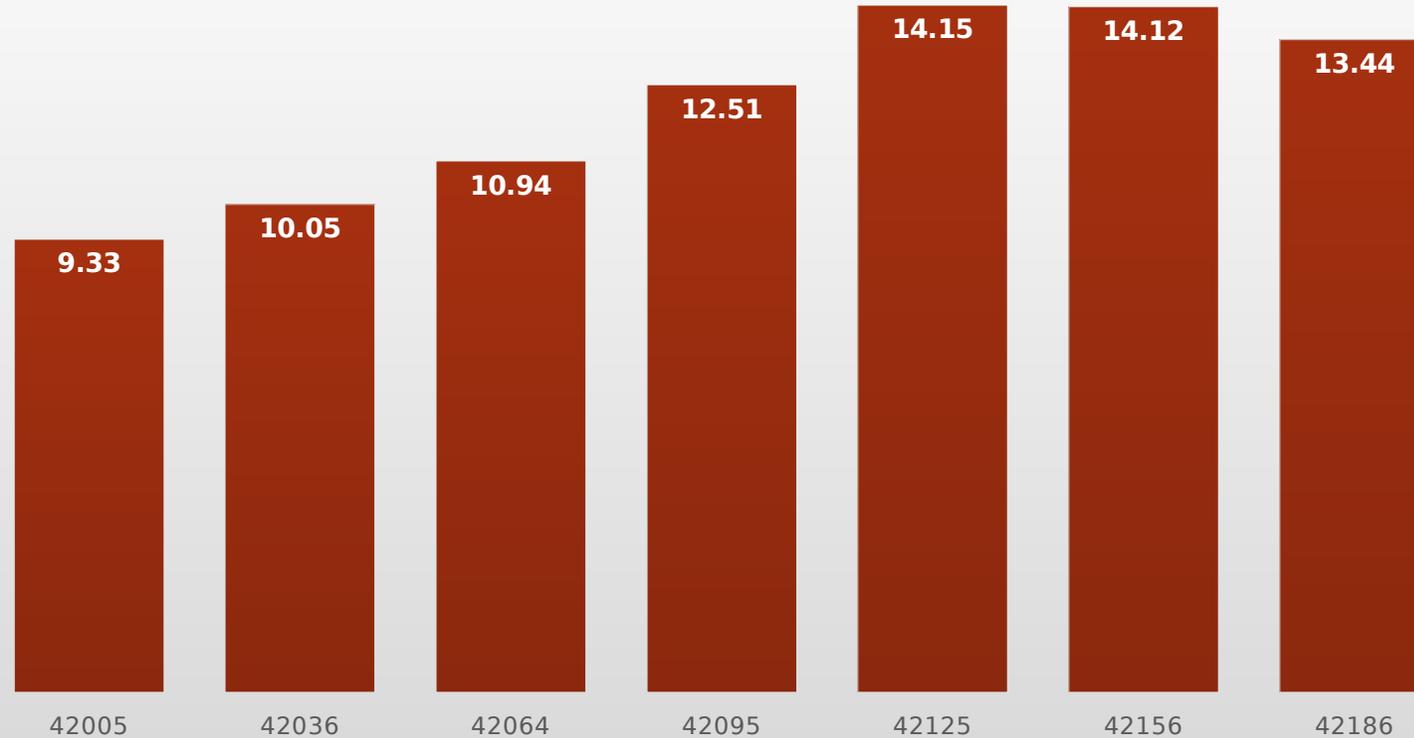


Qualitative Process

- Build, enhance qualitative capacity.
- Continued improvement in this area through collaboration with Central Office / Office of Research and Development.
- Current Qualitative Activities include:
 - Regular record and case / care plan reviews
 - Supervision activities that support quality planning and programming
 - Oversight activities
 - Data report development
 - Regular reports generated and used
 - Activities to ensure or improve data quality

Clinical Contacts

Average Number of Clinical Contact Hours per Youth



Seclusion Data

