The Ukeru Evolution

ukeru

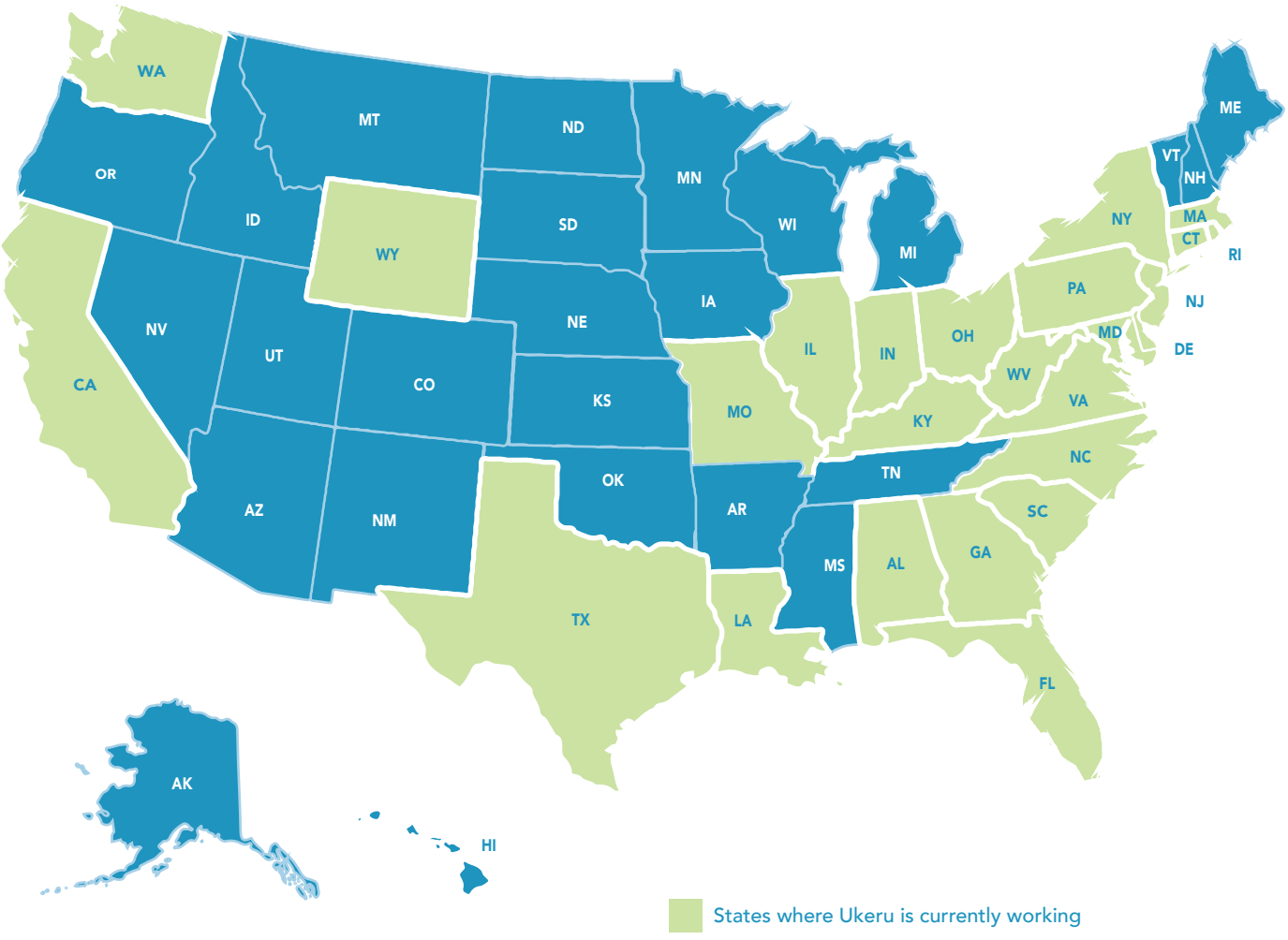
It Starts with U

Thank you for your interest in Ukeru®, the first national crisis intervention program to offer an alternative to the use of restraints and seclusion as accepted behavioral management tools!

Our award-winning program has helped behavioral health providers and schools reduce the use of restraint, seclusion, and injury, while lowering workers' compensation costs and employee turnover. We believe that all intervention — educational and behavioral — should be built on an approach of comfort versus control. To help make this a reality, we provide training on the conceptual ideas — such as trauma informed care and conflict resolution — as well as the physical techniques that minimize the need for restraints and seclusion.

We know that no one wants to use restraint or seclusion to manage behavior. But when fear and frustration take over, they believe they have no other choices. Ukeru wants to change that!

If we are going to make a real change, we have to offer training that recognizes why an individual is exhibiting a particular behavior and how to offer meaningful intervention, which includes a safe, physical alternative to restraint.



The Need for Ukeru

At Ukeru, we take to heart the importance of a trauma-informed approach. For individuals who have experienced traumatic events, the impact of re-experiencing that trauma through the use of restraints and seclusions can be devastating. This trauma may take the form of what we traditionally think of, such as physical abuse, severe neglect, loss, and domestic violence. But it also may take the form of bullying, shame, fear and anxiety.

When a child or adult experiences adverse treatment methods such as restraint and seclusion, that current experience is compounded by past trauma. This leads to more aggression and fuels a psychologically destructive cycle. Research shows that reducing and preventing restraint and seclusion practices can enhance quality of treatment and increase satisfaction for those both receiving and providing services.

WHAT IS TRAUMA?

Trauma is an experience of violence and victimization which can include :

- Sexual abuse
- Physical abuse
- Severe neglect
- Loss
- Domestic violence and/or the witnessing of violence
- Bullying
- Shame
- Fear
- Anxiety

THE IMPACT OF TRAUMA

Childhood trauma can:

- Affect cognition and behavior for decades.
- Lead to symptoms similar to those of veterans returning home from war with post-traumatic stress disorder.
- PTSD — Be experienced by at least **33%** of youths who experienced community violence.

Increased incidents of childhood trauma are correlated with increased risk of problems with:

- Health
- Family
- Finances
- Jobs

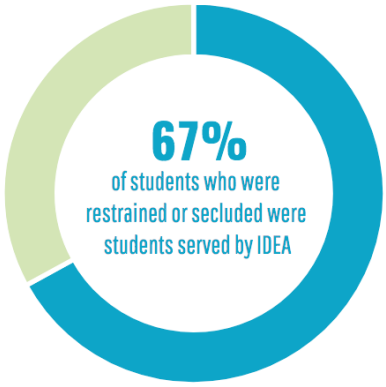
People who have experienced trauma are:

- **15x** More likely to attempt suicide
- **4x** More likely to become an alcoholic
- **3x** More likely to be absent from work

Restraint & Seclusion:
A Discriminatory Practice in Schools

Children with disabilities – **particularly those with intellectual disabilities, behavioral problems, & communication or sensory related disabilities** – are disproportionately secluded and restrained in classroom settings on a regular basis.

HOWEVER



Another report indicated that **¾ of students restrained** each year have physical, emotional or intellectual disabilities

Violating the rights of students with disabilities to free appropriate public education (FAPE):

Treating them differently

Reducing time spent in the classroom

Creating unequal educational opportunities

A trauma-informed educational experience makes the classroom setting safer for both teachers and ALL students:

Teachers are taught physical restraint and seclusion as the default approach for students who are acting out.

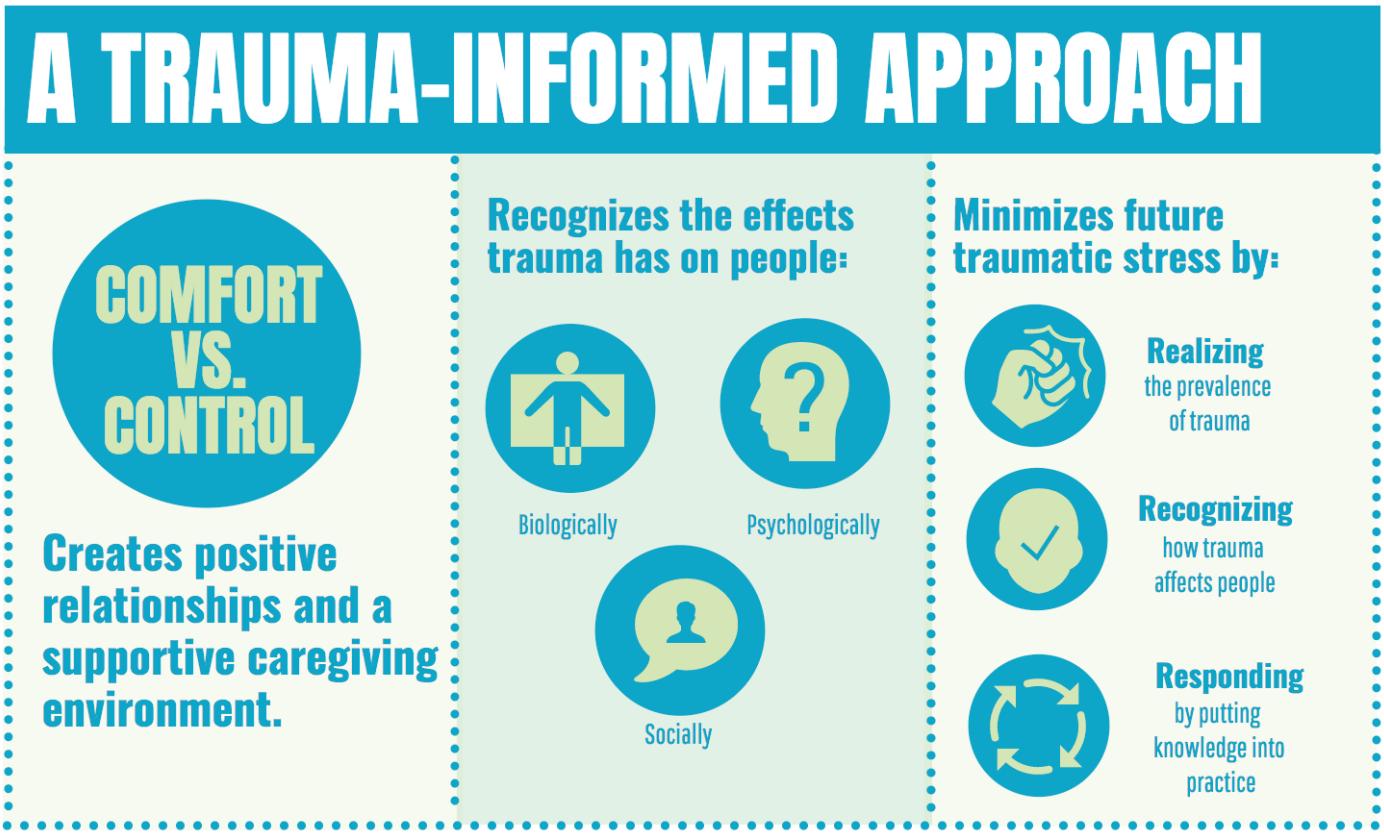
Instead, educators should receive **proper training** on meaningful intervention including safe, physical alternatives.

The Grafton Story

Grafton Integrated Health Network — an organization serving children and adults with autism and co- occurring psychiatric diagnoses — had over 6,600 annual cases of restraint in 2003. In response, the organization issued a mandate to eliminate restraints without compromising employee or client safety. Unable to find an appropriate training program already established, Grafton employees created their own with a core philosophy of comfort over control. This method provided an alternative approach to physical and emotional submission.

Within a 10 year span, **Grafton reduced the use of restraints by 99.8 percent,** lowered workers' compensation policy costs and reduced employee turnover for a total **return on investment of over $17 million**. Client induced **staff injuries have been reduced by 69.5 percent** and staff injuries from restraints have gone from a high of 126 in FY05 to one in FY17.

Leaders from Grafton understood that this new approach needed to be shared. They named the new training technique Ukeru, Japanese for "receive."



How We Can Help U!

Ukeru helps organizations reduce or, where possible, eliminate the use of restraint and seclusion in three ways:

1

Training: Led by the team that developed Ukeru, training is provided on key concepts — such as trauma-informed care and conflict resolution — as well as the physical techniques and tools that help manage challenging behavior. Ukeru teaches how to eliminate seclusion and provides a physical alternative to restraint. Customized to fit the unique needs of your organization, Ukeru offers direct participant trainings as well as a train-the-trainer series. Training is straightforward, easy to implement, and focuses on what caregivers want to do most – communicate effectively with clients and avoid stressful, escalating behaviors.

2

Equipment: With the same innovative spirit that has driven the organization since its inception, Ukeru developed patented, custom-made, cushioned blocking tools that keep both professionals and those in their care safe and comfortable.

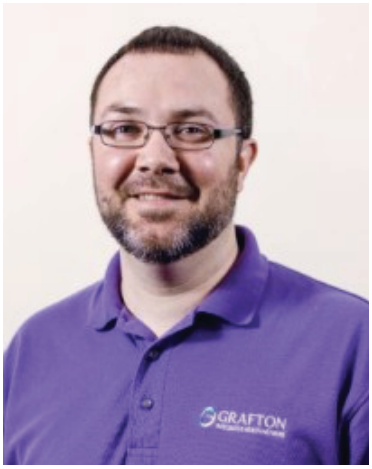
3

Culture change: Ukeru provides comprehensive organizational assessments and tailored plans to help shift cultures and create sustainable change that results in an environment focused on comfort rather than control.

Our Team

Kimberly Sanders, *President, Ukeru Systems*

Kim Sanders has worked with children and adults with autism and other developmental disabilities for over 25 years. Kim has served in a series of both hands-on and leadership roles in Grafton facilities, including Case Manager, Direct Support Professional, Residential Administrator and Executive Director, and Executive Vice President. Kim has presented at the national and international level on the Minimization of Restraint and Seclusion model, and she is recognized as an innovator for moving towards a physical restraint free environment at Grafton. Kim holds a BA in Psychology and a MS in Strategic Leadership.



Christopher Feltner, *Training and Performance Architect*

Christopher has worked at Grafton Integrated Health Network for eight years. During his tenure, he has worked as an Instructional Assistant, Trainer and Training Support Manager. Christopher has helped develop and train Ukeru across Grafton's multiple regions along with training Ukeru to external organizations across the United States, and in Australia.

Christopher has studied various martial arts since the age of nine and has competed in wrestling and submission grappling. These interests have provided him with a thorough insight into body mechanics, which in turn has allowed him to break down the physical techniques of Ukeru for staff in very unique ways.

Christopher has a BA in Speech Communication from James Madison University with a specialized focus in Interpersonal Communication. He also holds an Associate of Science with an education focus from Lord Fairfax Community College.

Ray Crosen, *Learning Engineer*

Before joining the Ukeru team, Ray held a variety of jobs at Grafton Integrated Health Systems including Direct Support Professional and Residential Administrator. He has also worked in all regional areas within Grafton. But most interestingly, Ray was instrumental in helping develop the Ukeru model during his time at Grafton.

Ray holds the unique perspective of seeing how Grafton was transformed by the Ukeru philosophy and continues to be a champion for its effectiveness as a trauma-informed approach in addressing behavioral challenges.

.

Our Team

Robert "Patrick" North, *Learning Engineer*

Patrick North has been with Ukeru's parent organization, Grafton Integrated Health Network, for over seven years, working in increasingly responsible roles within the organization. Starting as a Direct Support Professional, he soon was promoted to behavior interventionist, then program supervisor, then Training Support Manager and, most recently, Residential Administrator of Grafton's Psychiatric Residential Treatment Center. Patrick has experience in all facets of the behavioral health field, making him an invaluable source of knowledge for the many organizations implementing Ukeru in their facilities.

In 2014, Patrick became an Ukeru champion, training both Grafton staff as well as over 600 individuals in organizations across the United States. He has extensive experience training professionals in programs that serve individuals with intellectual, developmental and psychiatric challenges.

Dori Sanders, *Digital Publicist*

As Ukeru's Digital Publicist, Dori Sanders focuses on increasing connections with like-minded individuals and organizations across social media platforms. Her efforts to digitally engage stakeholders has been, and continues to be, critical to spreading the comfort vs. control message and building excitement around Ukeru's mission. Dori is currently attending Shepherd University working toward her Bachelor of Science in Business Administration and a Master of Business Administration.

Frequently Asked Questions

What is Ukeru®?

Ukeru is a crisis management technique rooted in the belief that the use of physical restraints is unnecessary and unproductive. We believe that all intervention — educational and behavioral — should be built on an approach of comfort rather than control.

What does "Ukeru" mean?

Ukeru is the Japanese word for "receive." This word encapsulates our entire philosophy; at its heart, Ukeru is about treating those that depend on you in a way that you would want to be treated. The way we provide care should be the same as the way we would want to receive care.

What makes Ukeru different from other crisis management techniques?

Other crisis management programs may seek to minimize restraint and seclusion; however, these approaches are still taught to be used in the case of an "emergency."
In contrast, Ukeru centers on a philosophy of comfort vs. control:

- Using a trauma-informed approach to create a supportive, caregiving environment sensitive to clients' past experiences of violence and victimization.
- Helping individuals thrive in the least restrictive environment consistent with achieving the best outcome.
- Achieving the greatest impact with the least amount of disruption to an individual's routine.

How was Ukeru developed?

A decade ago, our parent organization, Grafton Integrated Health Network (Grafton) issued a mandate to eliminate restraints without compromising employee or client safety. Since then, the organization has reduced the use of restraints by more than 99 percent, dramatically reduced the number of injuries to clients and staff and has significantly increased the rate of treatment goals mastered across the organization.

In 2015, based on its experience and success, Grafton launched Ukeru Systems, a safe, comforting and restraint-free crisis management program developed by and for behavioral health professionals and paraprofessionals, educators and parents. Today, the Ukeru team travels the country, training others on these techniques.

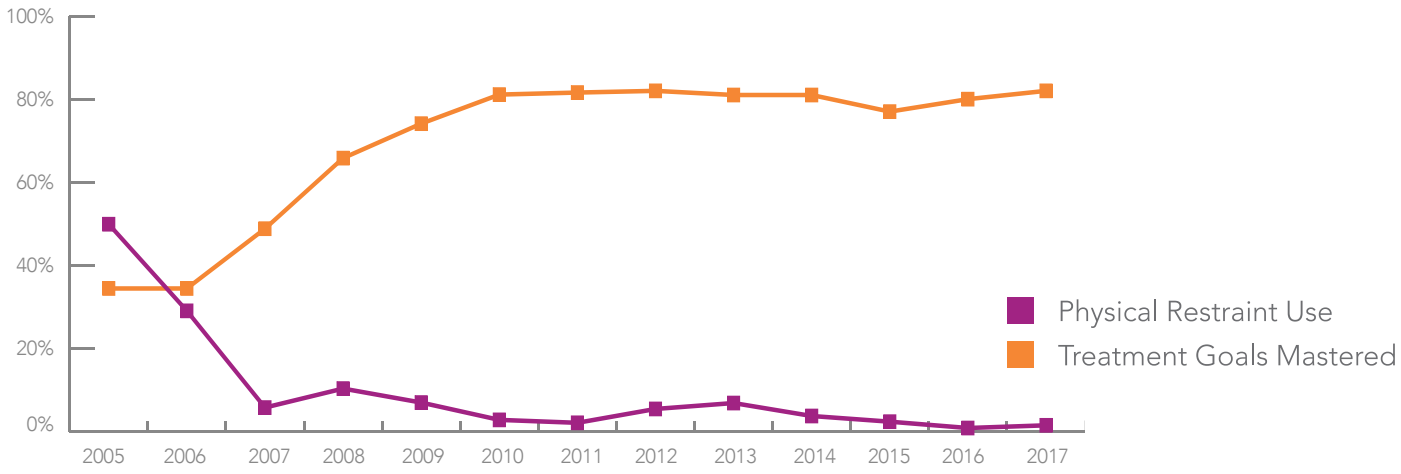
Won't minimizing restraint and seclusion compromise the safety of clients and staff?

No. Research shows that minimizing restraint and seclusion can enhance quality of treatment and increase satisfaction for those both receiving and providing services.
By way of illustration, since launching Ukeru Grafton has decreased client-induced staff injuries, workers compensation premiums, lost time, modified duty days and turnover.
What are restraints and seclusions?

Restraints and seclusions are coercive, high-risk techniques used to contain a child or adult considered a danger to themselves or others.

- Seclusion involves complete isolation, either for a short or extended amount of time.
- Restraints are manual methods that reduce the ability of a person to move his/her arms, legs, body or head freely.

These practices are employed in a multitude of settings including behavioral health care facilities, public schools and detention centers, among milieus.



Why is minimizing restraint and seclusion important?

Evidence shows that restraint and seclusion are ineffective behavior modification techniques that have potentially deadly consequences. Further, these are not evidence-based practices; there is no data to suggest that either leads to reduced violent or uncontrolled behavior. In fact, behavioral research indicates that restraint and seclusion actually cause, reinforce and maintain aggression and violence. Using these types of approaches often lead to increased violence and volatility for all involved.

What is a trauma informed approach?

A trauma informed approach creates a supportive, caregiving environment sensitive to clients' past experiences of violence and victimization. With a high likelihood of past trauma impacting one or more of the individuals involved in any given scenario, ensuring adequate support for these experiences is critical. A trauma-informed approach is critical tool to ensure a supportive environment that minimizes traumatic stress.

People Are Talking About Us!

Testimonials

ABOUT THE NEED FOR UKERU

"I want people to understand that it is never okay to put your hands on someone else. I want people with Autism to be more supported, comfortable and learn to be more in control of their own behavior."
– Veronica Federiconi, Autism Services

"My teachers are thrilled with Ukeru and the response has been overwhelmingly positive. I announced at the last principal's meeting that we are no longer going to use our previous training system. Instead, we are now using Ukeru exclusively as a county school system."
– Former Public School Administrator

ABOUT THE RESULTS

"People who, in the past, could not move from one room to the next without challenges are now out in the community, working and engaging in meaningful activities of interest. People who used to require several staff for assistance at all times are now walking around with little to no risk of harm to themselves or others, with minimal staff supports."
– Veronica Federiconi, Autism Services

ABOUT THE TRAINING

"As you block you are continually in dialogue. You never stop communicating, but with no hands on. Ukeru offers an alternative that is safer and more respectful of the person being served. It forces you to change the expectation of what is acceptable."
– Betty Holland, Former President & CEO Sunshine Communities

"Ukeru is very personal. A lot of other systems have been around a while and they are clearly businesses. With Ukeru, there is a different level of accessibility and discussion. For trainers, it's very interactive. Even after the training, Ukeru is very helpful in terms of responding to ongoing questions. It is a true partner in helping to create and maintain a restraint free environment."
– Mark Gleason, Chief Operating Officer, Northwestern Community Services

WHAT PARENTS HAVE TO SAY

"He is not at all violent like he was before. When he does have outbursts now, it's an anomaly. And, on those rare occasions, the Grafton team is able to de-escalate — rather than try to restrain or seclude him — by redirecting him."
– Mother & Advocate Rhonda Richardson

Ukeru in the News

THE HILL

Making safer and more equitable classrooms requires change

BY KIM SANDERS, OPINION CONTRIBUTOR - 02/17/17 06:20 PM EST

Like many other issues in our country right now, a case before the United States Supreme Court, Endrew F. vs. Douglas County School District, is causing heated national debate.

The case involves a child with autism in Colorado whose parents are suing the school district over whether he is being denied his legal right for a meaningful education in the public school setting.

At the root of the argument is the level of education public schools are required to provide students with disabilities. Existing legislation defines this requirement as "free appropriate public education." But, what does that really mean? There are those who interpret it as "some" education — often understood as the bare minimum — while others believe it should be defined as providing "meaningful," substantial benefit. Beyond this "blizzard of words," as Justice Alito described it, is an even more pressing issue – one that presents the greatest barrier to learning for children with disabilities.

Children with disabilities — particularly those with intellectual disabilities, behavioral problems, and communication or sensory related disabilities — are disproportionately secluded and restrained in classroom settings on a regular basis. According to recent data from the U.S. Department of Education, students with disabilities comprise two-thirds of the 277,000 children who are secluded from their classmates or restrained annually, despite representing only 12 percent of the overall student population.

Why is this important in this particular case? If a special needs student is spending the majority of their day restrained or in a seclusion room, it doesn't matter how challenging the lessons, what goals are set or how good the intention; a child simply can't learn if they are in emotional or physical submission for the majority of the school day.

Surely, a free appropriate education, regardless of the nuances used to define that term, ensures children are not physically or emotionally abused.

However, for many years, teachers have been taught that physical restraint and seclusion as the default approach when a student acts out. Until educators are given training that offers meaningful intervention, which includes safe, physical alternatives to use before restraint or seclusion, our classrooms will not be productive educational environments for any child, not just children with disabilities.

While these “behavioral modification techniques” have historically been considered appropriate, we now know these techniques have potentially deadly and, without question, traumatic consequences. They are not evidence-based practices and there is no data to suggest that either leads to reduced violent or uncontrolled behavior. In fact, research indicates that restraint and seclusion actually cause, reinforce and maintain aggression and violence. And they are certainly barriers to education.

As demonstrated by the Supreme Court case, parents are often the greatest advocates. New statistics recently released by the Office of Civil Rights (OCR) cites a significant increase in complaints involving restraint and seclusion of children with disabilities.

According to the report, Securing Equal Educational Opportunity, the overall number of complaints filed last year with the U.S. Department of Education's OCR soared to a record 16,720, with the largest increases in the areas of restraint or seclusion of students with disabilities.

I anticipate the number of complaints will continue to rise unless educators are given training that offers meaningful intervention and alternatives to restraint and seclusion. Only then will these complaints decrease.

But this can be done. Grafton Integrated Health Network — an organization serving children and adults with autism and co-occurring psychiatric diagnoses — initiated an agency-wide restraint reduction over a decade ago, achieving compelling results: reducing the use of restraints by 99.8 percent and significantly reduced the number of injuries to both clients and those who care for them.

Today, Grafton is helping other organizations’ to do the same through Ukeru Systems, a division of the organization which provides training for a safe, comforting and restraint-free approach to crisis management.

So while I applaud the debate about what an “appropriate” education looks like for children with disabilities, we are skipping a fundamental first step. Before we can educate children, we have to stop hurting them.

Kim Sanders is President of Ukeru Systems, a division of Grafton Integrated Health Network, which trains direct support professionals, teachers, clinicians and others in the conceptual and technical elements of trauma informed care, physical restraint-free crisis management approaches, and conflict resolution

Behavioral Healthcare EXECUTIVE

What Works: Alternatives to physical restraint

by Tom Valentino, Senior Editor

Sometimes the best ideas come from those who have been in the weeds the longest.

With a history of using traditional, physical, crisis-management tactics, Grafton Integrated Health Network, a Winchester, Va.-based not-for-profit behavioral health and special education services provider, found it could no longer advocate for the approach. By 2003, the organization had a direct-care staff turnover rate of 54%. Numerous injuries to staff members by patients in crisis also drove up its worker's compensation insurance premium to an untenable $2.5 million. Relations between staff and clients were strained.

"There was seclusion, restraint, timeout, restitution—everything you could imagine when you think of restrictive practices," says Kim Sanders, executive vice president at Grafton. "Over time, as that culture grew, it was highly controlling and somewhat negative. We had staff who felt like helpless, hopeless victims. They were working with the toughest individuals who couldn't be served in schools or live with their families. They'd come in day in, day out, and get hurt or injured."

Sanders, who has been with Grafton since 1989, experienced firsthand the challenges direct-care staff faced: Among her past roles, she served as a residential instructor from 1990 to 1993, providing residential care and supervision of students with severe disabilities and maladaptive behaviors.

Turning point

CEO Jim Gaynor, who arrived at Grafton in 2002, told his leadership team that changes needed to be made, particularly in the company's crisis management protocols. In time, working hours were rearranged, but the bigger change was the home-grown development of an alternative to restraint for crisis management.

The "Ukeru" program is based on the principle that restraint is unnecessary and unproductive and that intervention should be built on comfort, not control. Instead of using restraint or seclusion to quell potentially combative clients, staff were instructed to use soft materials, such as a beanbag, to shield themselves while talking with clients to de- escalate them.

Feelings of fear and frustration had plagued staff at Grafton in the past, Sanders says. Implementing less aggressive protocols addressed that and strengthened the therapeutic alliance between staff members and clients

"If I can hold up a beanbag and block you while you are being aggressive and trying to attack me, I take away the majority of that feeling of fear," Sanders says. "I'm much calmer and can stick with you. I'm not going to do anything intrusive like hold you against your will. I can continue to say kind, compassionate things to you if that's what works for you."

Otherwise, care staff could react in counterproductive ways that escalate the crisis, by running away or shouting, for example.

Staff initially used couch cushions, throw pillows and large beanbags as shields. Umpire's gear and karate blocking pads were also implemented before Grafton teamed with an outside vendor to develop proprietary pads.

An orientation process known as "presenting the pad" helps familiarize clients with the pads. The pads are kept out in the open at Grafton, and It's not uncommon to see clients leaning on them to watch TV or for children at a Grafton facility to use the pads to build forts, Sanders says.

Dramatic improvement

With the implementation of the program, Grafton reports a significant reduction in the use of restraint at its facilities, as well as the elimination of the use of seclusion, according to Sanders. Direct-care staff turnover has been reduced to 30%. Grafton leaders estimate the use of Ukeru has saved the company over $15 million since 2004.

In December, Grafton announced the launch of Ukeru Systems as a commercial product available to other treatment centers. Sanders says the organization hopes it can help behavioral healthcare providers relying on traditional physical crisis management protocols find alternatives.

Takeaways

Are your behavioral healthcare organization's crisis management protocols up to par? Consider the following indicators:

- Track the use of restraint and seclusion. By 2003, Grafton direct care staff was using restraint 6,600 times and seclusion 1,500 times for the 220 individuals served in a given year, prompting the organization to begin exploring physical alternatives.
- Review your worker's compensation costs. Because of numerous injuries to staff members, Grafton faced a worker's compensation insurance premium of $2.5 million in 2003 and struggled to find a private insurance provider.
- Listen to your staff. Before the implementation of Ukeru, Sanders says Grafton employees felt a sense of hopelessness and helplessness. As a result, the organization saw a direct care staff turnover of 54%

www.ukerusystems.com

For more information:
info@ukerusystems.com
540-542-0200 x 6412

[i] *Promoting Alternatives to the Use of Seclusion and Restraint* – Issue Brief #4. SAMHSA, 2010
[ii] IBID
[iii] IBID
[iv] According to the Substance Abuse and Mental Health Services Administration