Moving in the Direction of Youth-Centered Programming in Residential Treatment Centers

as a Strategy for Reducing Restraints

presented by

Jack Nowicki, LCSW

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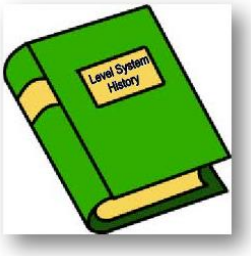
Texas Network of Youth Services
PO Box26855
Austin, Texas 78755
Ph: 512-815-3299
WWW.TNOYS.ORG
jnowicki@tnoys.org

HISTORY AND USE OF LEVEL SYSTEMS

History of Use of Level Systems



Level and point systems were originally used in residential youth-care as a token economy or operant conditioning strategy designed to remediate problem behaviors and to reinforce positive, pro-social behaviors.[1] They have been used in RTCs since the 1960's and were basically "an application of the principle of shaping, where the goal is self-management."[2] Some of the major components of these approaches to behavior change include:

1. Positive Reinforcement ~ increasing the desired behavior by rewarding it when it occurs.
2. Schedule of Reinforcement ~ in general reinforcing desired behaviors immediately increases their frequency. As the desired behavior becomes more frequent, increasing the time between rewarding the desired behaviors helps to generalize the behavior to more situations.
3. Operant Conditioning ~ Changing voluntary behaviors that are reinforced and maintained by their consequences (either positive or negative).
4. Shaping ~ rewarding or reinforcing approximations of a desired response set such that a behavior is eventually learned.
5. Extinction ~ decreasing consequences of any behavior such that it is no longer reinforced and therefore inconsequential.
6. Taking points away and/or moving down levels (response cost) can only be effective when the youth can move back up quickly once his behavior has recovered. If the youth has a poor self image, gets a sense of failure, or is not sufficiently built their schedule of reinforcement, these negative consequences can lead to failure of the system.

Effective Level Systems

According to Cancio & Johnson, level systems are most effective when the systems are well designed and implemented to:

- "motivate (and) improve behavior" (p.513)
- "restore (youth's) lost hope or expectations for success" (p.515)
- "allow (staff) opportunities to increase their rate of praise" (by the) "…development of positive therapeutic relationships" (p.513)
- "enable (youth) to see a cause and effect relationship between their pro-social behavior and the consequences they receive" (p.513)
- "be clear regarding (positive) behaviors being monitored and reinforced" (p.513)
- give "frequent and consistent feedback regarding their behavior, especially in initial levels of the level system" (p.514)[3]
- "provide (positive) behavioral feedback more often (twice an hour)" (p.517)
- "have (youth) fill out reinforce preference surveys… (to assist staff) in developing a reinforce menu to post…" (p.517)

In general, the authors suggest that system must be much more related to reinforcing the target or goal-related behavior than it is related to behavior reduction or negative consequencing focus. Good systems must include a good problem and goal assessment protocol, "strategies to identify the antecedents and consequences of problem behavior"[4], and social skills training for youth.

[1] Mohr, W., Martin, A, et.al (2009) Beyond point and level systems: Moving toward child-centered programming. *American Journal of Orthopsychiatry (79)*1, pps 8-18

[2] Cancio, E., & Johnson, J. (2007) Level system revisited: An important tool for educating students with emotional and behavioral disorders. *International Journal of Behavioral Consultation & Therapy, (3)*4, pps 512-527; [3] p. 520

[4] See also: Mohr, Martin, et.al. p. 10; "…reinforcers should be presented immediately after a desired response for maximum effectiveness."

DECONSTRUCTING LEVEL SYSTEMS: THE RATIONALE

Key Trends in Residential Care

In 2004 Leiberman reported that key trends in residential treatment include(ed) "…standardizing care models, keeping youth in residential treatment for shorter lengths of time, getting families involved, moving to evidence-based practice, and changing organizational structures" [5] These kinds of changes, along with the many different diagnostic features of youth in care and current thinking about the adverse and traumatic effects of violence on child development lead to questioning the use of normative systems based on contingency management of youth behavior.

Other support for moving beyond normative systems like token economies and level systems include:

- Child injuries and death in care stemming from restraints
- Lack of positive treatment outcomes from punitive management systems
- Past history of abuse being triggered in residential care
- The business case: insurance, liability, licensing issues, and bad publicity[6]
- Research about increasing positive outcomes in care

Get Rid of Our Level System? Not Today, thank you.

Even though current research and best practices suggest that moving away from level systems and towards individualized programming, is the wave of the future in residential care, many facilities are not ready to discontinue their level systems.

There are changes that facilities can make without dropping their level systems that relate to decreasing restraints and seclusion. Some of the easiest and best ways to move in this direction include:

1. Sharing with staff that the intention of the agency to reduce restraints and seclusion by asking staff to do whatever works to avoid restraining youth.
2. Working with staff to build more positive relationships with youth: pre-escalation skills; giving options; teaching social skills; etc.
3. Focusing on prevention of problems; identifying conditions that are challenging for youth; intervening BEFORE behavior escalates, and building an emotional alliance with youth.
4. Training staff in the effects of past trauma on youth's current behavior.[7]
5. Using safety plans with youth on a regular basis: asking "What would you rather be doing than having this issue?"
6. Focusing on using the level system to reward behavior and progress and finding other ways to consequence misbehavior when possible

[5] Nowicki, J., & Pestine, A. (2015). Transitioning from level systems to youth-centered programming in residential treatment centers as a strategy for reducing restraints and seclusion. *Relational Child & Youth Care Practice*, *28*(1).

[6] LeBel, J. (2011). The business case for preventing and reducing restraint and seclusion use. *HHS Publication No.(SMA)*, 11-4632.

[7] Heuberger, J., Newton, L., Lary, B., et.al. (2012) Moving away from points and levels. In the Massachusetts Department of Mental Health's Resource Guide: Creating Positive Cultures of Care, 3rd Edition, available online at Resource Guide: Creating Positive Cultures of Care (PDF)

TRAUMA-INFORMED CARE AND INDIVIDUAL GOAL-DIRECTED BEHAVIOR

Review of 6 Key Restraint Reduction Strategies

Kevin Huckshorn's recent restating of the Six Core Strategies:

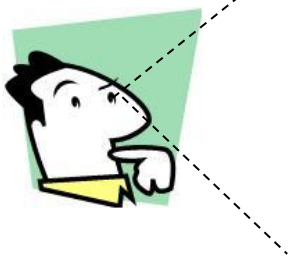
Strategy One: Leadership. Agency **"**…develops a mission, philosophy and guiding values which promote non-coercion and the avoidance of restraint".
Strategy Two: Performance Measurement. Agency "…takes a 'systems' approach and identifies performance measures which determine the effectiveness of its restraint reduction plan and which measure key outcomes for customers".
Strategy Three: Learning and Development. Agency "…develops its staff with the knowledge and skills to understand and prevent crisis behavior".
Strategy Four: Providing Personalised Support. Agency "…uses restraint reduction tools which inform staff and shape personalised care and support to customers".
Strategy Five: Communication and Customer Focus. Agency "…fully involves customers in a variety of roles within the service, identifies the needs of customers and uses these to inform service provision and development".
Strategy Six: Continuous Improvement. "The principle of post-incident support and learning is embedded into organisational culture". [8]

Outcome-Oriented Youthwork

In residential treatment we are working at helping youth improve their capabilities as problem solvers, learning to control their behavior, and finding ways to communicate more effectively to get what they want. We want to engage the youth in their treatment and make positive change rewarding and fun. Research on counseling shows that the single most important variable linked to positive outcome is "client involvement" When youth are involved in the program they benefit the most. Also, the second most important variable related to positive outcome is the alliance with the counselor (caregiver, staff, etc) as reported by the client. When the youth report a good relationship with staff AND they are involved in the program, there is a great possibility of achieving their treatment goals.

Staff Skills Needed

According to Cancio & Johnson, "…the quality of (staff-youth) relationship is the foundation for all other aspects of (facility) management."[9] In research conducted in classroom level systems "…teachers who had high-quality relationships with their students has 31% fewer discipline problems and rule violations." [10] All staff can improve the progress, and thereby decrease the use of lowering levels of youth in the program by:



- Keeping youth problem behavior from escalating
- Staying calm when giving corrective feedback to youth
- Helping youth "experience success, have realistic expectations of what (youth) can do, and create a positive (environmental) climate." [11]
- Showing youth dignity and respect and treating them as individuals
- Building strong personal relationships that are different than the youth expect from most adults they have known!
- Utilizing praise at a high rate and bringing their interests and activities into the forefront.
- "…advocating for (youth), communicating caring and support, practicing fairness, and having high expectations" [9] (for their continued success)

[8] Huckshorn, K. (2015) An evidence-based practice to prevent vonflict and violence in inpatient and residential settings. CPI Conference, 2015. Available online at the Restraint Reduction Network Website: http://restraintreductionnetwork.org/latest-news/keynote-preview-six-core-strategies/
[9] Cancio, E., & Johnson, J. (2007), p. 521; [10,11] p. 522

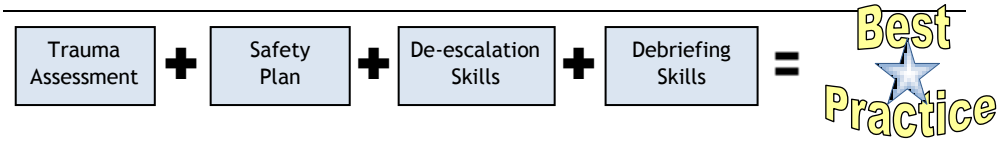
Appendix 1

THREE "BEST PRACTICE" STRATEGIES OF TRAUMA-INFORMED CARE

Trauma Informed Care

The move towards youth programs becoming "trauma-informed" and providing "trauma-informed care" is related to the preponderance of data and evidence of past history of abuse and traumatization of youth utilizing social and mental health services. Newest data confirms that 46% of all children surveyed were physically assaulted in 2008![12] Of course, most of the youth in treatment have history of violence and abuse in their lives. It stands to reason that the more youth-workers know about trauma and abuse and their aftereffects, the better we can provide services for this population of youth.

Basic Flow of Trauma-informed Services



Further descriptions of these trauma-informed strategies follow!

Trauma Assessment

Part of developing trauma-informed care has to do with finding out the trauma history of youth coming in for services by focusing on the following:

1. Current safety, including:
   a. Danger of injury to self or others, including suicidal/homicidal thoughts or behavior, ability to keep self safe from harm.
   b. Immediate vulnerability to maltreatment or exploitation by others, including behaviors o situations that may "trigger" behavior that will be problematic in the program.[10]
2. An assessment of past trauma like the Adverse Childhood Experiences (ACE) scale for collecting data and opening a discussion about any past trauma.[13]
3. Listing "triggers" the youth knows of that may remind them of past trauma, cause discomfort, fear, or anger, or re-traumatize them.

According to the CDC, "almost two-thirds of our (ACE) study participants reported at least one adverse childhood experience, and more than one of five reported three or more ACEs. The short- and long-term outcomes of these childhood exposures include a multitude of health and social problems"[14]

Creating a Safety Plan

During the intake with a youth in residential care, staff should create a Safety Plan for the youth as part of the trauma history assessment and treatment planning process.

Intake staff asks the youth about problem behavior that may come up during the placement, including what kinds of things may "trigger" youth's upset, unsafe, or angry feelings; any warning signs the youth may know they have, and how the staff can best respond to the youth to help them calm down or avoid escalating their behavior.

[11] Finkelhor, D., Turner, H., et.al. (2009) Children's exposure to violence: A comprehensive national survey. *OJJDP Juvenile Justice Bulletin, Oct. 2009.* Retrieved online February 22, 2011 from http://www.ncjrs.gov/pdffiles1/ojjdp/227744.pdf

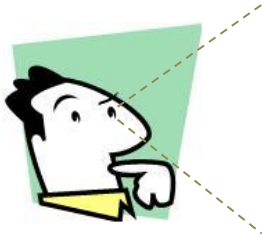
[12] Harris, M. & Fallot, R. (2001): Using trauma theory to design service systems. *New Directions in Mental Services, 89.* San Francisco: Jossey-Bass.

[13] Briere, J., & Lanktree, C.B. (2008). *Integrative Treatment for Complex Trauma in Adolescents (ITCT-A): A Guide for the Treatment of Multiply-Traumatized Youth.* Long Beach, CA: MCAVIC-USC Child and Adolescent Trauma Program, National Child Traumatic Stress Network, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, p. 10. Available online at http://www.johnbriere.com/articles.htm

[14] Adverse Childhood Experiences Study. Center for Disease Control Website. Retrieved online November 2010 from http://www.cdc.gov/ace/findings.htm

THREE "BEST PRACTICE" STRATEGIES OF TRUAMA-INFORMED CARE

Staff Building De-escalation Skills



De-escalation skills may be one of the most important skill set practitioners (especially residential youth-workers) need to use daily in their jobs. According to Gordon Hodas, "Staff untrained in relationship building and in de-escalation may conclude that they possess few if any alternatives other than physical force, when a child is out of control. …The actions and behavior of some children will …provoke negative personal reactions – anger, anxiety, hurt, and (those) should not be expressed or acted upon."[15] Here is Hodas' list of abilities and acumen needed by youth-workers today.

1. "Awareness of the stressful nature of working with troubled children and in institutional settings.
2. Awareness of one's own strengths and vulnerabilities as a person and professional.
3. The ability and desire to identify areas in need of professional development.
4. The ability to recognize angry and other negative personal reactions, when they arise.
5. The ability to manage and control anger and other negative personal reactions, when they arise, so they are not acted upon against the child.
6. The consistent use of one's supervisor and the supervisory structure, and one's peers."[16]

Here are some "core competencies" Hodas suggests:

Active listening.	Asking questions.	Using a soothing voice
Facilitating non-stressful conversations.	Acknowledging legitimacy of youth's grievance.	Highlighting evidence of child's coping.
Encouraging the youth's problem solving.	Using skills learned in training.	Offering support and concern.
Allowing the child to save face.	Getting to really know the youth.	Seeking input from other staff.
Judicious use of humor without sarcasm.	Asking youth for help – "Help me to help you."	Redirecting the youth towards solutions
Reminding the youth of their goals, strengths, and past accomplishments.	Helping youth understand the current crisis in terms of past trauma.	Asking directly, "How can I help?"

[15,16] Hodas, G.R.(2005) Empowering direct care workers who work with children and youth in institutional care. Harrisburg: Pennsylvania Office of Mental Health and Substance Abuse Services. Retrieved online Oct. 6, 2010 from http://www.parecovery.org/documents/Hodas_Direct_Care_Worker.pdf p. 10