

EMPOWERING DIRECT CARE WORKERS WHO WORK WITH CHILDREN AND YOUTH IN INSTITUTIONAL CARE

INTRODUCTION:

This paper offers a vision and a framework to support the efforts of administrators, program directors and supervisors to empower direct care workers who work with children and youth (*children*) in institutional care. There is increasing recognition that many children have “serious emotional disturbance “ (SED) as well as exposure to severe, chronic trauma, even though many of these children have not been identified as such (NASMHPD and NTAC, 2004). The ultimate goal is for direct care workers to maximize their effectiveness with children in their care, so that the children can address the challenges that led to their admission and successfully return to the community. This involves efforts by the direct care worker to address the child’s mental health needs, promote skill building and prosocial conduct, work with the child’s family and community based resources, and help child and family prepare for the child’s discharge. When the above tasks are actively pursued respectfully and collaboratively, with the worker seeking to understand the perspectives of the child and family and building on strengths, then the process will likely promote the child’s resiliency in response to adversity as well (Coatsworth and Duncan, 2003).

The discussion to follow is, in reality, applicable to all staff working with children, including therapists, educators, psychologists, and child psychiatrists. It is, however, especially relevant to direct care workers, given their central role with children in institutional care, whether in Mental Health, Child Protection, or Juvenile Justice. The ideas are also applicable to direct care workers working in community settings, including Special Education, in-home services, and community-based activities.

Direct care workers, sometimes referred to within Mental Health as “mental health workers” and “mental health techs” and by other terms in other systems, are typically individuals with a high school diploma, although some may have a higher terminal degree, and a specified amount of experience working with children in human services. Despite their limited formal training (and, at times, limited clinical experience), direct care workers typically have the most frequent contact with children and, often, the greatest influence. These individuals frequently enter the field with a strong sense of purpose and the desire to make a difference for children. Yet they often receive insufficient training and supervision, and may experience themselves as unsupported. In addition, understanding the concept of a therapeutic boundary – which guides the direct care worker to serve as a caring professional and not a friend to the child, thereby reducing the possibility of a conflict of interest or inappropriate conduct – requires orientation and training. No program can effectively meet the needs of its children without an effective, well-trained cadre of direct care staff. This, in turn, requires a strong commitment by program leadership to promote the professional development of its workforce.

THE CONTEXT THAT SHAPES DIRECT CARE STAFF FUNCTIONING:

We begin with the recognition that a program cannot help children without effectively trained and guided direct care workers. There are, in addition, other prerequisites for an effective program that meets the needs of its identified population of children. Ten key parameters are identified below:

1. The agency's organizational culture and leadership, from the top down. This involves a well formulated, written treatment philosophy that guides the treatment milieu and all interpersonal relationships, which is actively promoted and modeled by agency leaders.
2. The agency's commitment to strengths based treatment, including respect for each child and his/her family and openness to input from them.
3. The agency's commitment to prevention (primary, secondary, and tertiary), and to what is known as "trauma informed care" (a systematic effort to identify childhood trauma and help the child understand its impact and begin to heal) (NETI, 2003).
4. The agency's ability to remain child-centered, so that implementation of policies, procedures and "rules" is flexible enough to address the child's needs and does not become the primary goal in itself.
5. The agency's openness to input from staff at all levels, as the basis for information gathering, collaborative problem solving, and program improvement. Staff need to feel "safe" and valued in providing input, since concern for losing their job keeps many quiet.
6. The degree of individualized information about the child that is initially obtained from child, family and referral source and then updated on a regular, routine basis and shared among staff. This includes obtaining a trauma history and the collaborative development of a safety plan with the child (also known as a de-escalation preference survey).
7. The agency's ability to empower the child, by helping the child understand the connection between one's life experience, including past trauma exposure, and current coping efforts.
8. The agency's commitment to the training, supervision, and professional development of its staff.
9. The agencies commitment to, and ongoing implementation of, an ongoing quality improvement process (CQI), based on the premise that the program needs to adapt to the needs of children, rather than children adapting to an unchanging program.
10. The cultural competency and diversity of staff, which should reflect the diversity of the resident population. It is helpful for all staff to appreciate that each child and family, regardless of religion, ethnicity, and race, has its own unique culture.

THE VISION FOR EFFECTIVE DIRECT CARE WORKERS – CREATING THERAPEUTIC RELATIONSHIPS THAT CONVEY RESPECT AND HOPE:

An agency's identified protocols, interventions and usual practices notwithstanding, it is staff relationships with children, conveying respect and hope (Frank and Frank, 1991), that constitute the primary basis for therapeutic change. Therefore, the agency vision needs to promote the development and maintenance of such relationships.

Direct care workers need to understand that relationship building with children with SED, prior traumatic experiences, multiple losses, drug and alcohol problems, and/or externalized behavior is far from easy. Guardedness is typical and may actually be protective for the child. Relationship building requires time, patience, use of relevant individualized information, and a readiness to follow the lead of the child. An ability to listen and withhold judgment is indispensable. The relationship needs to be person-to-person, not just worker-to-client. This means that the direct care worker relates to the child first as a human being, and only then as someone with identified problems or challenges. Genuine caring is essential, since the child can readily surmise when a staff person is feigning interest and "going through the motions." A respectful relationship is collaborative rather than primarily hierarchical in nature. A child learns respect not through lectures but through repeated experiences of being respected. In some manner, verbal or otherwise, the direct care worker conveys the idea that "we need to work together to understand what is going on and how to help you out – I don't have all the answers myself."

The direct care worker is not a therapist to the child, but their relationship should certainly be "therapeutic" in nature – e.g. organized around clearly identified efforts to implement the child's treatment or service plan, and to promote the child's adaptation, coping, and capacity for self-expression and self-advocacy. The direct care worker constantly seeks to expand individualized information about each child – the child's strengths, vulnerabilities, triggers, sources of coping and de-escalation, etc. In order to develop and maintain strong connections with children, the direct care worker must present him/herself in a warm, accepting, non-intimidating way, always using the relationship to meet the child's needs rather than to have personal needs met. Since children learn more from actions than from words, the direct care worker needs to serve as a role model for the child. Above all, the direct care worker must avoid shaming and humiliation, since such interventions lead individuals toward revenge and violence, not constructive change (Gilligan, 2001).

FROM SOUP TO NUTS – INTRODUCING AND MAINTAINING THE VISION:

While a few staff may intuitively understand and implement the above vision (these individuals are sometimes referred to as "naturals"), it is important to recognize that the ability to cultivate and maintain therapeutic relationships with children represents a set of values and skills *that can be taught*. The following constitute some of the opportunities and settings to embed the values and promote the skills.

1. The written agency Mission and Philosophy statements.

2. The written job description of staff worker expectations, including skills that maintain a therapeutic culture, promote the resiliency and recovery of children in care, and enable the avoidance of restraint and coercion.
3. The initial job interview with, and screening of, the applicant, so that appropriate individuals are hired and inappropriate ones turned away.
4. The initial orientation of newly hired staff, encompassing general program operations and specific approaches to prevention, de-escalation, and safe crisis management.
5. Ongoing staff training throughout the calendar year.
6. Ongoing staff supervision and mentoring.
7. Periodic performance evaluations.
8. Linking of relationship building with children to the data system and the Quality Improvement process.

THE FRAMEWORK TO EMPOWER DIRECT CARE WORKERS – THREE KEY DOMAINS:

We propose 3 key domains of functioning that – strategically used within an agency in such settings as identified above – can ultimately empower direct care staff and thereby improve the quality of care for children. These domains broaden the perspective and skill sets of direct care staff, and involve the following: 1) values and beliefs; 2) job-specific expectations and competencies; and 3) professional self-awareness and self-control. We suggest that Human Resource and program staff that interview job applicants ascertain the extent to which each individual brings *therapeutically based values and beliefs, appropriate competencies, and the capacity for self-awareness and self-control*. Based on these factors, in association with the individual's overall profile (professional qualifications, work history, references, manner of self-presentation, and personal characteristics), appropriate hiring decisions can be made. Thereafter, it becomes the responsibility of the agency to embed therapeutically based values, skills, and capacities in direct care staff through comprehensive hiring, orientation, training, supervision, and performance evaluation criteria that incorporate the above elements.

VALUES AND BELIEFS:

The first key domain, which can either empower or handicap direct care workers, involves their values and beliefs. In general, values and beliefs organize our perceptions of children and their families, and therefore greatly influence our subsequent interactions and interventions with them. While a person is free in their private life to maintain any values and beliefs they choose, the direct care worker's role involves being "therapeutic," and therefore their values and beliefs need to be therapeutically based. Fortunately, considerable consensus

has been achieved as a result of the national system of care movement and the formulation of CASSP (Child and Adolescent Service System Program) Principles, based on ground-breaking work in the 1980's at the National Institute of Mental Health in Washington D.C.

CASSP Principles, as affirmed in Pennsylvania by multiple stakeholders (OMHSAS, 1995) stipulate that services to children and their families need to maintain certain characteristics that grant them legitimacy and promote the vision of shared relationships and hopefulness. In summarized form offered here, CASSP Principles involve the following:

1. child-centered (organized around the actual strengths and needs of the child, and individualized in nature),
2. family-focused (recognizing the central role of parents and the family in raising children, and building upon family participation and leadership for both a specific child and in overall policy development),
3. community-based (supporting the child's remaining in the home and community, whenever possible, or returning to the community as soon as possible when in placement, and using services and resources convenient to the family, within the community),
4. multi-system (collaborative efforts at meeting the child's needs by all involved child-serving system representatives and stakeholders),
5. culturally competent (recognizing the unique cultural characteristics of each child and family, and ensuring that services support and build upon this culture),
6. least restrictive/least intrusive services and interventions (ensuring that services effectively address the needs of the child without involving unnecessary restriction of movement or intrusion into child and family living).

Consistent with CASSP Principles and such related concepts as "strengths based treatment" (an ongoing commitment to identify the multiple strengths of the child, family, community and service system, and to build upon them while providing services), there are certain values and beliefs on the part of direct care staff that predispose toward therapeutic relationships. These relate to the worker's view of the following: 1. children, 2. families, 3. treatment, and 4. personal motivation to serve as a direct care worker.

1. Values and Beliefs About Children:

Direct care workers need to understand that children are different from adults, in that they possess less knowledge and fewer skills and are engaged in a very critical process of physical and psychosocial development, with brain maturation in fact continuing into the mid-20's. Given the fluidity of child development and the potential resilience of children, it is important that staff avoid labeling or stereotyping children negatively, based on their behavior and conduct.

A partial list of therapeutic values and beliefs for direct care staff regarding children includes the following. Children should be viewed as:

- a. Significantly different than adults, due in part to an extensive, rapid developmental process, which staff need to recognize and promote.
- b. Doing the best they can, given current circumstances and limitations (limitations typically involve knowledge, skills, stability, and support).
- d. Survivors, whose behavior reflects adaptation to adverse circumstances, limited skills, and physiological imbalances. Children therefore should not be viewed as “bad,” “manipulative,” or “attention seeking.”
- e. In need of understanding, respect, support, and redirection – not control, “management,” coercion, or shaming.
- f. In need of encouragement to recognize and build on their strengths and competencies.
- g. Possessing a capacity for resilience and positive change, when offered appropriate treatment and support.
- h. Capable of active participation in their own treatment, when offered the opportunity for meaningful partnership with staff.

2) Values and Beliefs About Families:

Direct care workers ideally recognize the many challenges that families (broadly defined to include the nuclear family, extended family, and highly committed others) face in trying to raise a child, particularly one with special needs. When there is also poverty and scarcity of services, the challenges multiply. With such considerations in mind, and consistent also with a commitment to remain strengths-based, the direct care worker needs to disavow such concepts as “the dysfunctional family.”

A partial list of therapeutic values and beliefs for direct care staff regarding the family includes the following. Families should be viewed as:

- a. Caring and competent.
- b. Experts in relation to their child – and therefore key sources of information.
- c. Partners in treatment, not individuals to be blamed.
- d. Allies to professional staff.

3) Values and Beliefs About the Nature of Treatment:

Direct care staff cannot be effective if, in reality, they do not believe that mental health treatment and/or therapeutically based interventions in child welfare and juvenile justice can make a positive difference in the lives of children. While it may be naive to assume that all mental health treatment is beneficial, direct care workers should not view services as a “waste of time” or the children being served as being “beyond help.” Stigma cannot be effectively challenged when those entrusted with the care of children privately endorse these same beliefs.

A partial list of therapeutic values and beliefs for direct care staff regarding the nature of treatment includes the following. Mental health treatment, along with therapeutic interventions in related child-serving systems, should be viewed as:

- a. Viable and meaningful.
- b. Mediated through relationships and the restoration of hope.
- c. Facilitated by a team process in which team members collaborate together.
- d. Focused on accountability and natural consequences, not on punishment.
- e. Involving the absence of violence, threats, and coercion towards children.
- f. Respecting the integrity of the child’s body and avoiding use of restraint, except in an extreme emergency as a last resort to maintain safety.
- g. Involving ongoing efforts to help the child identify constructive choices.

4) Values and Beliefs Underlying Personal Motivation:

It is important that individuals seeking to work with children in placement be motivated to work in such settings for appropriate reasons. A key involves being committed to the job and the children, not just “passing through.” Gratification for the direct care worker should come from helping children, not controlling or using them.

What follows is a partial list of therapeutically based rationales for an individual seeking employment as a direct care worker:

- a. A desire to help children, not control or exploit them.
- b. A desire to “give back” to the community and to others.
- c. A desire to provide children the positive experiences they deserve.
- d. A desire to learn and grow as a professional and not just “pass through.”

JOB-SPECIFIC EXPECTATIONS AND COMPETENCIES:

The second key domain to empowering direct care staff involves identifying and promoting job-specific expectations and related competencies. Typically, job-specific expectations and competencies are based on concepts of “professionalism,” which include such elements as timeliness, reliability, attentiveness, honesty, personal appearance, judgment, documentation and record keeping, and the maintenance of respectful, non-abusive relationships. Such expectations are fundamentally sound and appropriate. Especially important are the personal characteristics of the individual. An effective worker is one who seeks influence through relationships rather than coercion. Such an individual tends to be flexible and curious, recognizing the need to listen rather than judge the child, and has a readiness to function as part of a team. There is a sense of ease in the presence of others, whether involving the child or families and outside professionals (see Hansen et al, 1996, for a broad discussion of family and community competences).

Despite the importance of relationship building in the work of direct care workers, the search for job competencies does not always preferentially explore this dimension. The discussion below considers the skills involved in relationship building and in the subsequent use of therapeutic relationships to benefit the child.

1. Relationship Building:

Relationship building begins with the direct care worker’s assuming a therapeutic persona, which involves a consistent manner of presenting oneself to children. Whether intuitively chosen or the result of careful reflection, a persona that is therapeutic is one in which the direct care worker is warm, accepting, and non-intimidating. This manner of presentation creates a welcoming environment that offers interpersonal safety to the child. The goal is for the child to view the direct care worker as being committed to the child’s wellbeing, such that the child would respond affirmatively if asked “The Cardinal Question” (The Cardinal Question for the direct care worker involves the following: “Given the totality of my relationship with this child, does the child view me as being on his/her side?” [Hodas, 2003, 2004b]).

Once formed, therapeutic relationships can be used at all times to promote the child’s wellbeing.

2. Use of Therapeutic Relationships:

A therapeutic relationship should be used to help the child implement the individualized treatment plan and to promote the child’s coping and adaptation. On a routine basis and in the absence of a particular crisis or concern, this involves the direct care worker’s being regularly available to the child, offering input, support, and feedback as appropriate. Efforts to be strengths based and to proactively anticipate the needs of the child constitute the essence of *primary prevention*, which aims to promote the child’s overall wellbeing and avoid crisis. The direct care worker can help the child learn to cope effectively by being familiar with, and implementing, the child’s treatment or care plan, and by making use of information provided

by the child that has been incorporated in the development of an individualized safety (prevention) plan for the child.

When a crisis does occur or appears imminent, the direct care worker offers quick intervention in order to address the problem early and prevent further escalation. Sometimes, supportive statements and low-key redirection suffice and the situation can be resolved uneventfully. At other times, however, the direct care worker needs to intervene more intensively by using a variety of de-escalation approaches, with the goal of defusing the situation, avoiding need for restrictive physical procedures such as physical restraint, and restoring safety and calm. Efforts to address and resolve crisis in the least restrictive and intrusive manner are part of what is known as *secondary prevention*. All effective primary and secondary prevention efforts build upon pre-existing relationships between the direct care worker and the child.

Unfortunately, in some instances, primary and secondary prevention efforts fall short, and the child may require application of a restrictive procedure on an emergency basis to maintain his/her safety or that of others. The decision to use physical restraint should never be made lightly, since being restrained is not therapeutic and in fact often traumatizes or re-traumatizes the child. *Tertiary prevention*, once a restraint is terminated as quickly as clinically appropriate, involves efforts to learn from the experience so that future restraints become less likely. Key elements of tertiary prevention involve processing with the child, once safety and stability have been restored. Informal processing takes place shortly after the restraint is discontinued. A more formal processing (known as formal debriefment) should occur the next day, involving the child, program leaders, and others working with the child, including the family whenever possible.

3. Importance of De-Escalation Skills for Staff – Staff Core Competencies:

Given the importance of de-escalation as a skill set to soothe and settle a distressed child and as a tool to avoid the need for physical restraint, it is important that direct care workers have extensive training in a range of de-escalation approaches and interventions. 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. In addition, de-escalation cannot be implemented solely as a “technique” in the absence of a caring relationship and a strong commitment on the part of involved staff to guide the process to a non-violent resolution.

Below are some useful approaches to de-escalation. While not inclusive, the list can serve as a guide to administrators, program directors, supervisors, and direct care workers themselves. It should be appreciated that many of these same skills, identified here as de-escalation methods, also constitute appropriate primary interventions for staff as they get to know the child and work on developing a trusting relationship. De-escalation core competencies include the following:

1. Listening.
2. Remaining calm and non-judgmental.

3. Offering support and concern.
4. Being soothing through voice and manner.
5. Having a non-stressful “conversation” with the child.
6. Acknowledging the legitimacy of some aspect of the child’s concern or grievance.
7. Highlighting current evidence of child’s coping, despite distress.
8. Avoiding shaming and humiliation.
9. Using previously obtained information and previously completed tools.
10. Asking questions.
11. Expanding one’s knowledge base about the child.
12. Reminding the child of own goals, strengths, and past accomplishments.
13. Helping the child understand the current crisis in terms of past trauma experiences.
14. Asking directly, “How can I help?”
15. Asking the child for help – “Help me to help you.”
16. Providing space, and time, as indicated.
17. Judicious use of humor (always avoiding sarcasm and put-downs).
18. Redirection, ensuring the child opportunity to save face.
19. Openness of staff person to input from other staff, as indicated.
20. Other.

PROFESSIONAL SELF-AWARENESS & SELF-CONTROL:

The third key domain to empowering direct care staff involves assessing and promoting *professional self-awareness and self-control*. This constitutes an area infrequently targeted in training, supervision, and especially performance evaluations. Direct care staff soon enough learn that intensive contact with troubled, challenging children can be highly stressful. It is preferable that staff be oriented to this dynamic from the outset. They also need to understand that, no matter how professional and “objective” they may try to be, the actions and behavior of some children will nevertheless provoke negative personal reactions – anger, anxiety, hurt, and

other emotions that should not be expressed or acted upon. In the absence of self-awareness and the capacity for self-control, the direct care worker may engage in counter-aggression toward the child, destabilizing both the child and the milieu. In fact, there is increasing awareness that counter-aggression and over-control by staff underlie many episodes of physical restraint (NETI 2003, Hughes 2002).

The following constitutes a partial list of the kind of knowledge and capacities needed by the direct care worker in order to remain therapeutic despite negative personal reactions:

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 angry 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.

STAFF RETENTION AND MORALE:

At a time when there is a significant manpower shortage in human services, it is important for agencies to retain their staff and maintain staff morale. It is also important that the need to fill staff positions not lead to the indiscriminate hiring of available applicants, irrespective of their qualifications and suitability to work with troubled children.

One issue frequently identified by direct care staff as a source of considerable concern involves the insufficiency of salary. Direct care staff justifiably argue that their salary structure in no way reflects their level of responsibility, or the degree of impact that they typically have on children in their care. Many staff find it necessary to hold two or more jobs in order to continue to work with children. Maintaining two or more jobs creates fatigue, and takes staff away from time with their own families. It thus becomes difficult for the individual to maintain the personal balance so necessary for effective direct care work. Related to the need for a realistic salary structure is the need for opportunities for direct care staff for advancement within the agency. When direct care positions are essentially dead-end jobs, it becomes difficult for talented staff to carve out a career for themselves doing such work. As a result, dedicated staff may leave prematurely, and new staff may look upon their position as time-limited, until something more remunerative comes along. Morale is difficult to achieve when staff feel underpaid and undervalued.

In addition to addressing salary-related issues, there are many ways that facilities can promote staff retention and morale. Staff morale tends to be high when staff feel competent, respected, and supported. Staff need to understand in advance the stressful nature of working with children, so that they can remain child-centered and not “take it personally.” Hence, the importance of the intensive level of orientation, training, supervision, and mentoring described earlier. Staff also want to make a difference, so supervisors need to help their supervisee identify their positive reasons for entering the field and then reinforce, over time, the worker’s personal sense of mission. It is important for an agency to identify and celebrate success, whenever it occurs. Similarly, the agency should endeavor to help the worker learn from mistakes. Staff also need to feel safe at the job. This encompasses both physical and emotional safety. Staff do not want to be subjected to constant physical aggression from children, some of which might cause considerable physical harm. Similarly, staff do not want to feel as though they are out there alone, and that they will be blamed when something goes wrong.

Agencies committed to staff empowerment through appropriate hiring, orientation, training, supervision, mentoring, and performance evaluation increase the likelihood of positive staff morale and staff retention. In particular, staff with the knowledge, belief and values, and core competencies to create a therapeutic environment, recognize and address trauma, and provide alternatives to use of restraint are likely to find substantial satisfaction from their work. In fact, recent research provides solid evidence of many positive benefits of restraint reduction, not only for children but also for staff. LeBel and Goldstein found that reduction of restraint in child and adolescent Inpatient hospitals in Massachusetts resulted in better clinical outcomes and significant cost savings for the facilities. In addition, there were fewer injuries to children and staff, and lower staff turnover (2005). For example, staff turnover decreased by 80%, and the number of workdays missed due to restraint-related injury decreased by 98%. The use of worker sick time decreased by 53%, and the use of replacement staff decreased by 78%. These changes were associated with increased staff availability to address the treatment needs of the children and, in general, improved staff work conditions.

CAVEATS:

There are potential roadblocks to the empowerment of direct care workers and the provision of effective care and treatment to troubled children, and well-meaning programs should recognize and address these. First, staff empowerment, in association with restraint reduction, cannot be viewed as just “one more agency activity.” It must be seen as a priority and receive the intensive planning and monitoring that it requires. There is need for concern toward those facilities that assert that they are “doing it already” without first undertaking a review of its culture and practices. There is need for similar concern toward those facilities that assert that they “cannot afford” to undertake the necessary changes.

It is important that facilities and staff appreciate that restraint reduction is part of a larger commitment, which involves supporting the dignity and wellbeing of each child, individually and within the context of family and community. Coercive practices, whether physical or psychological, need to be avoided. Intimidation and violence, or the threat of these, cannot be tolerated or overlooked.

Facilities need to understand what the child needs and does not need. In association with individualized care, some generalizations can be made. For example, children can be assumed to *need* the following:

1. Therapeutic relationships.
2. Active treatment that addresses the child's needs and promotes wellness.
3. Understanding about one's life and the likely sources of one's problems.
4. Family involvement, to the extent possible.
5. Community connections.
6. Voice.
7. Choice, with opportunities for active participation.

In like manner, it can be assumed that there are certain experiences that children *do not need*, which include the following:

1. Intimidation.
2. Threats.
3. Violence.
4. Abuse and neglect.
5. Shaming and humiliation.
6. Breaches of confidentiality that have not been previously agreed upon.

Finally, it is important that an agency identify and disseminate a clear philosophy of treatment or care, to guide staff interventions at all levels. Without a unifying philosophy, staff will likely over-focus on the child's surface behaviors, with insufficient attention to the underlying forces that drive the child.

CONCLUSION – A TIME OF OPPORTUNITY:

Now is a time of opportunity to improve the treatment and interventions offered to children with challenging problems, whether it involves SED, drug and alcohol use, antisocial and disturbing behaviors, or the consequences of neglect, abuse or other trauma. There is an increasing emergence of evidence-based interventions for children, and a consensus that programs should collect data related to both individual and aggregate outcomes (President's New

Freedom Commission on Mental Health, 2003). The new field of trauma-informed care (NETI 2003) highlights the seriousness of trauma in the lives of children and reinforces our recognition that effective interventions begin with meaningful relationships. Staff with a trauma informed orientation understand that coercion and restrictive procedures are counter-therapeutic and reflect treatment failure at the program level (Hodas 2004a). Physical interventions, or their threat, create instability and often traumatize and re-traumatize children (NETI 2003). It is therefore imperative that all programs working with children and youth work to reduce the use of restraint and other coercive practices. Fortunately, there is increasing evidence that such reductions can be achieved meaningfully and safely (Rivard et al, 2005, Rivard, 2004, LeBel et al, 2004, LeBel and Goldstein, 2005), with benefit to staff as well as children.

The stigmatizing of children, by both the lay public and some professionals, is a source of concern. Children are stigmatized not just for “mental illness” but also for disruptive behavior, without regard to the circumstances and life experiences underlying such behavior. Too often, it is presumed that the child is nothing more than the sum of his behaviors, even though these behaviors may be grounded in significant maltreatment and consequent neurobiological abnormalities (Perry et al, 1995, Perry, 2004). Trauma informed care tells us that the child does not always choose his behaviors, but can be assisted in making better choices (Hodas 2005).

Three domains – values and beliefs, professionalism that includes competency in relationship building, and self-awareness and self-control – represent critical starting points for programs committed to enhancing the quality, competence, morale, and sense of mission of its direct care staff. With the appropriate training, supervision, mentoring, and performance evaluation process, direct care workers can be assisted in addressing the treatment needs and promoting the wellbeing, resilience, and recovery of children. It is important not to underestimate the level of commitment and infrastructure needed to effectively train staff.

Children can experience a sense of wellbeing when they feel safe, their symptoms are being addressed, they begin to understand what has happened to them, and they are assisted in finding their voice and participating in their treatment. Specific wellness strategies include attention to diet, exercise, relaxation, pursuit of interests, and the maintenance of healthy relationships. Resiliency is promoted when the child develops new skills, modifies behaviors that are maladaptive, and learns how to accept help from others. Recovery, a concept most often applied to the adult population, is also of relevance to children and youth and their families. Children subjected to chronic maltreatment, and those dealing with other psychiatric disorders as well, must learn to function effectively and find purpose in their lives despite the persistence of some level of disability. A core element of recovery, and of a satisfying life, involves the development of a sense of personal meaning and a positive identity (Torry et al, 2005).

Many direct care staff bring desire and energy to the table. These assets must then be supported and channeled through training, supervision, and mentoring. Regardless of care setting, positive relationships and the offer of hope constitute the core elements of all effective helping (Frank and Frank, 1991). The message to the child, as suggested by Canada (1998), should be one of “salvation and forgiveness,” with reassurance that change is possible. Staff need to help children understand that we will not give up on them, so they in turn do not give up on themselves.

SUGGESTED READING

Allen, L. (1998, October). Deadly restraint. *Hartford Courant*.

Anderson, E. (1999): Code of the street: Decency, violence, and the moral life of the inner city. New York: Norton.

Bloom, S. (2003): The Sanctuary Model: A trauma-informed systems approach to the residential treatment of children. In *Residential Group Care Quarterly*, 4 (2). Washington DC: Child Welfare League of America, pp. 1, 4-5.

Bryant, R. (2003): Acute stress reactions: Can biological responses predict Posttraumatic Stress Disorder? In *CNS Spectrums: The International Journal of Neuropsychiatric Medicine*, 8 (9), 668-674.

Burns, B. and Hoagwood, K. (2002): Community treatment for youth: Evidence-based interventions for severe emotional and behavioral disorders. New York: Oxford University Press.

Canada, G. (1998). Reaching up for manhood: Transforming the lives of boys in America. Boston: Beacon Press.

Child Welfare League of American (2004): CWLA Best practice guidelines: Behavior support and intervention training. Washington DC: Child Welfare League of America.

Child Welfare League of American (2004): Achieving better outcomes for children and families: Reducing restraint and seclusion. Washington DC: Child Welfare League of America.

Coatsworth, J. D. and Duncan, L. (2003): Fostering resilience: A strengths-based approach to mental health – a CASSP discussion paper. Harrisburg: Pennsylvania CASSP Training and Technical Assistance Institute.

Curie, C. (2005): Commentary: SAMHSA's commitment to eliminating the use of seclusion and restraint. *Psychiatric Services*, 56 (9), 1139-1140.

Donnelly, C. (2003): Pharmacologic treatment approaches for children and adolescents with posttraumatic stress disorder. Laor, N. and Wolmer, L. (guest editors): *Child and Adolescent Psychiatric Clinics of North America: Posttraumatic Stress Disorder*, 12 (2). Philadelphia: W.B. Saunders, 251-269.

Eth, S. (ed.), (2001). PTSD in children and adolescents. Washington DC: American Psychiatric Association Press.

Flannery, D., Singer, M., Wester, K. (2001): Violence exposure, psychological trauma, and suicide risk in a community sample of dangerously violent adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40, 435-442.

Frank, J.D, and Frank, J.B. (1991): *Persuasion and healing: A comparative study of psychotherapy*. Baltimore: Johns Hopkins.

Garbarino, J. (1999). *Lost boys: Why our sons turn violent and how we can save them*. New York: Free Press.

Garbarino, J. and deLara, E. (2002): *And words can hurt forever: How to protect adolescents from bullying, harassment, and emotional violence*. New York: Free Press.

Gilligan, J. (2001). *Preventing violence*. New York: Thames and Hudson.

Glod, C. and Teicher, M. (1996): Relationship between early abuse, PTSD, and activity levels in prepubertal children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 35, 1384-1393.

Goleman, D. (1995): *Emotional intelligence: Why it can matter more than IQ*. New York: Bantam Books.

Greene, R. (1998). *The explosive child: A new approach for understanding and parenting easily frustrated, "chronically inflexible" children*. New York: HarperCollins.

Groves, B. (2002): *Children who see too much: Lessons from the Child Witness to Violence Project*. Boston: Beacon.

Hansen, M., Anderson, C., Gray, C., Harbaugh, S., Lindbald-Goldberg, M., Marsh, D. (1996): *Child, family, and community core competencies*. Harrisburg: PA CAASP Training and Technical Assistance Institute.

Hardenstine, B. (2001): *Leading the way toward a seclusion and restraint-free environment: Pennsylvania's success story*. Harrisburg: Department of Public Welfare, Commonwealth of Pennsylvania.

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

Herman, J. (1992). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.

Hodas, G. (2001a). "Presuming the positive" as part of strengths based treatment in working with children and families, in *Guidelines to best practice in child and adolescent mental health services*. Harrisburg: PA Department of Public Welfare, 51-56.

Hodas, G. (2001b): *Working with children and adolescents who are defiant: Unconditional respect comes first*, in *Guidelines to best practice in child and adolescent mental health services*. Harrisburg: PA Department of Public Welfare, 63-68.

Hodas, G. (2003): Building relationships: The role of the direct care worker and the use of self in reducing seclusion and restraint. In Training curriculum for the reduction of seclusion and restraint. Alexandria, VA: NTAC.

Hodas, G. (2004a): Restraint and seclusion are therapeutic failures. *Residential Group Care Quarterly, 1*, Winter 2004, 11, 12-13.

Hodas, G. (2004b): Strengths based treatment for juveniles. Presentation to staff working at Pennsylvania's Youth Development and Youth Forestry Centers. Unpublished.

Hodas, G. (2005): Understanding and responding to childhood trauma: Creating trauma informed care. Alexandria, VA: NTAC (publication pending).

Huckshorn, K, (2003, revised 3/27/04): A snapshot of core interventions for S/R reduction. Alexandria, VA: National Executive Training Institute (NETI) and National Technical Assistance Center for State Mental Health Planning.

Hughes, W. (2002): Replacing control with empowerment is a proven solution. *Networks*, Summer and Fall. Alexandria, VA: NTAC.

Isaacs, M. (1992). Violence: The impact of community violence on African American children and families. Arlington, Va. National Center for Education in Maternal and Child Health.

Isaacs-Shockley, M., Cross, T., Bazron, B., Dennis, K., Benjamin, M. (1996): Framework for a culturally competent system of care. In Stroul, B (ed): Children's mental health: Creating system of care in a changing society. Baltimore: Brookes. 23-39.

Joint Commission on Accreditation on Healthcare Organizations (JCAHO) (2003): Restraint and seclusion standards for behavioral health. *2003 Comprehensive Accreditation Manual for Behavioral Health Care*.

Kaplan, S. and Pelcovitz, D. (issue editors) (1994): Child abuse. *Child and Adolescent Psychiatric Clinics of North America, 3:4*. Philadelphia: W.B. Saunders.

LeBel, J., Stromberg, N., Duckworth, K., Kerzner, J., Goldstein, R., Weeks, M., Harper, G., LaFlair, L., Sudders, M. (2004): Child and adolescent restraint reduction: A state initiative to promote strengths-based care. *Journal of the American Academy of Child and Adolescent Psychiatry, 43* (1), 37-45.

LeBel, J. and Goldstein, R. (2005): The economic cost of using restraint and the value added by restraint reduction or elimination. *Psychiatric Services, 56* (9), 1109-1114.

Lewis, D. (1998). Guilty by reason of insanity: A psychiatrist explores the mind of killers. New York: Fawcett Columbine.

Mahoney, K., Ford, J., Ko, S., Siegfried, C. (2004): Trauma-focused interventions for youth in the juvenile justice center. Washington, DC: Juvenile Justice Working Group of the National Child Traumatic Stress Network, www.NCTSNet.org.

National Association of State Mental Health Program Directors (NASMHPD) and National Technical Assistance Center for State Mental Health Planning (NTAC) (2004): The damaging consequences of violence and trauma: Facts, discussion points, and recommendations for the behavioral health system. Washington, D.C.: U.S. Department of Health and Human Services (HHS).

National Executive Training Institute (NETI) (2003): Training curriculum for the reduction of seclusion and restraint. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

National Executive Training Institute (NETI) (Draft, 2004): Core intervention fidelity measures. Alexandria, VA: National Technical Assistance Center for State Mental Health Planning.

National Institute on Drug Abuse (NIDA) (1997): Preventing drug use among children and adolescents: A research-based guide. NIH Publication No. 02-4212.

Office of the Surgeon General (2001): The Surgeon General's Report on Children's Mental Health. Washington, D.C: Department of Health and Human Services.

Office of the Surgeon General (2001): Youth violence: A report of the Surgeon General. Washington, D.C: Department of Health and Human Services.

Perrin, S., Smith, P., Yule, W. (2000): Practitioner review: The assessment and treatment of Post-traumatic Stress Disorder in children and adolescents. *J. Clin. Psychol. Psychiat.*, 41, 277-289.

Pennsylvania Office of Mental Health and Substance Abuse Services (OMHSAS) (1995): Child and Adolescent Service System Program (CASSP) Principles.

President's New Freedom Commission on Mental Health (2003): Achieving the promise: Transforming Mental Health Care in America, Available at the following website: <http://www.mentalhealthcommission.gov/reports/FinalReport/FullReport.htm>

Perry, B., Pollard, R., Blakeley, T., Baker, W., Vigilante, D (1995): Childhood trauma, the neurobiology of adaptation and use-dependent development of the brain: How 'states' becomes 'traits.' *Infant Mental Health Journal*, 16 (4): 271-291.

Perry, B. (2004): Understanding traumatized and maltreated children: The core concepts – Living and working with traumatized children. The ChildTrauma Academy, www.ChildTrauma.org.

Prothrow-Stith, D. (1991): *Deadly Consequences: How violence is destroying our teenage population and a plan to begin solving the problem.* New York: HarperPerennial.

Rasmussen, A., Vythilingam, M., Morgan III, C. (2003): The neuroendocrinology of Posttraumatic Stress Disorder: New directions, in *CNS Spectrums: The International Journal of Neuropsychiatric Medicine*, 8 (9), 651-667.

Rivard, J., Bloom, S., McCorkle, D., Abramowitz, R. (2005): Preliminary results of a study examining the implementation and effects of a trauma recovery framework for youths in residential treatment. *Therapeutic Community: The International Journal for Therapeutic and Supportive Organizations*, 1-12.

Rivard, J. (2004): Initial findings of an evaluation of a trauma recovery framework in residential treatment. *Residential Group Care Quarterly*, 5, Winter 2004, 3-5.

Substance Abuse and Mental Health Services Administration (SAMHSA). See the website: www.mentalhealth.samhsa.gov/child/childhealth.asp

Torry, W., Rapp, C., Van Tosh, L., McNabb, C., Ralph, R. (2005): Recovery principles and evidence-based practice: Essential ingredients of service improvement. *Community Mental Health Journal*, 41 (1), 91-100.

Van der Kolk, B. (2003): The neurobiology of childhood trauma and abuse. Laor, N. and Wolmer, L. (guest editors): *Child and Adolescent Psychiatric Clinics of North America: Posttraumatic Stress Disorder*, 12 (2). Philadelphia: W.B. Saunders, 293-317.

Wolpaw, J. and Ford, J. (2004): Assessing exposure to psychological and post-traumatic stress in the juvenile justice population. Washington, DC: Juvenile Justice Working Group of the National Child Traumatic Stress Network, www.NCTSNet.org.

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