

CHILD MANAGEMENT & DISCIPLINE

Jasper Mountain's Approach

! This statement describes how the agency approaches child discipline, and how we handle situations when a child has become unsafe to him/herself or others.

In a total therapeutic environment, the most potent vehicle for treatment is every staff/child, child/child and child/environment interaction. Therefore every interaction must be seen as significant and purposeful. In Agency residential program's, child management is not simply a question of behavioral control, and discipline is not just a way to extinguish problem behavior. Within the treatment environment, child management becomes instruction, modeling, and effective and responsive communication. Discipline follows the meaning of the term itself, which is "to teach." In other words, discipline is not a fancy word for punishment at Jasper Mountain. It is the foundation of behavior management as well as socialization. The goal is the real time instruction of appropriate social and interpersonal attitudes and behaviors. It is important to refer here to the mission and program philosophy that must guide all aspects of client care.



Discipline follows the meaning of the term itself, which is "to teach."

Overview of Approach

The principles of positive discipline shall be followed as outlined in staff training. No physical punishment will be used nor will any other type of punishment including withholding of basic needs be allowed. Logical consequences are usually the best teaching tools. Regardless of the intervention, its effect on the child and the situation is to be monitored for effectiveness and altered if the results are insufficient or producing negative side effects.



In the agency's approach to behavior management, the personal safety and personal worth of all clients are to be of uppermost importance at all times.

Specific interventions will be developed cognizant of the treatment plans for individual children. In this context, the personal safety and personal worth of all residents shall be uppermost in importance at all times. Violent behavior will not be allowed to occur without direct intervention. This is essential to the physical and emotional safety of everyone. Physical interventions will follow the principles of Nonviolent Crisis Intervention as outlined by Crisis Prevention Institute (CPI) with attention to the conditions and setting. All

interventions will be consistent with the treatment plan and according to the Agency policy on interventions. Any violent incident shall be immediately reported to the lead staff and to the appropriate program director as soon as possible. As often as possible, physical interventions that constitute a containment hold are to have more than one staff, interventions that do not constitute a hold should be observed by more than one staff.

The Agency uses several methods to insure safe, effective and best practices in the area of behavior management. Agency programs compile data on therapeutic holds. This information is reviewed on a monthly basis by the Quality Assurance Committee. The Agency data is compared to other treatment programs serving similar populations. The Board of Directors receives a program report each quarter that addresses the use of behavior management practices within the Agency. The Management Team is to annually review the Agency's use of behavior management practices to insure compliance with State and Federal law as well as best practices for treatment programs. Other principles of management and discipline will be addressed specific to individual children and in staff meetings and trainings.

Building Blocks of Treating Emotional Disturbance

Child management and discipline must also be viewed within the context of the "Building Blocks of Emotional Disturbance." Fundamental is that the parental figures for small children must always be firmly and responsibly in control of the environment. Management is a key to safety and security, and the first and most essential aspect of a treatment environment. Management means that at all times the children are aware that the staff are making the decisions in a safe and responsible way. In addition, the program must be free from conditions that promote mal-adaptive behavior.

Personal Worth	self acceptance, self respect, self love
Self-Awareness (18 months →)	exterior feedback insight
Relationship (12 – 24 months)	non-victimizing interplay of persons and roles
Trust (12 – 24 months)	respect, fairness, honesty, firmness, power
Belonging (12 – 20 months)	affection, roots, membership in group
Acceptance (12 – 18 months)	person vs. behavior
Security (6 – 18 months)	consistency, structure, locus of control
Safety (3 – 12 months)	predictability, non-violence, basic needs not threatened or conditioned

Jasper Mountain Interventions

Over the years, new staff members have repeatedly asked for an explanation of how and when interventions are to take place in the Agency. Most of the time what they have been asking for is an easy to understand formula as to what they should do in a certain situation. However, a formula or “cook book” approach to interventions has been resisted since the Agency began. Instead, staff have been trained and encouraged to become skilled clinicians with a growing understanding of the artistic qualities of treating children. While we strive for staff who are skilled and creative working with difficult populations we must recognize the rules and guidelines of interventions directed by Center for Medicaid Services, Oregon Addictions and Mental Health, Crisis Prevention Institute and the Council on Accreditation. The interventions outlined here have been carefully develop by the Management Team with input from agency trainers, program directors, and national priorities and requirements. The following position statement is both a policy and procedure. It is meant to outline the philosophy of the Agency regarding therapeutic interventions, and to describe the Agency’s practical approach to working with difficult to manage children. While some organizations subscribe to a behavior management system developed elsewhere, Jasper Mountain has such a uniquely challenging population that the organization has developed an approach taking ideas from numerous sources. The following position statement will stress that interventions are to be individualized, that alternatives are considered, and that when physical interventions are required to keep a child and others in the environment safe, these interventions are to be done appropriately and safely. This policy and the procedures outlined are intended to be in compliance with all federal regulations (42 CFR Part 483 Subpart G) including the Department of Health and Human Service’s Addictions and Mental Health rule governing restraint and seclusion as well as all State of Oregon regulations including the Administrative Rule 309-032-1500 and the State of California EC 49001; EC 56520; EC 56523.

THE PURPOSE OF INTERVENTIONS

The word “interventions” is a generic term to indicate the manner in which steps are taken to accomplish a prescribed goal. Treatment programs are fundamentally about accomplishing prescribed goals, and are therefore fundamentally about interventions. Over time therapeutic interventions, be they verbal, nonverbal, physical, environmental, or chemical, have maintained a positive and important place in the function of a treatment center. Although this is still the case, the modern world of regulations and liability have placed a questioning spotlight on physical interventions. In some ways this is good if a heightened awareness brings more effective physical interventions. However, this focus has often put a very effective form of treatment into a category of a “crisis,” and this line of thinking maintains that, “all crises are best prevented.” Understanding intensive treatment and its purpose, however, includes the understanding that in a treatment setting, problems cannot be ignored, behaviors cannot be allowed to go underground, and explosive issues cannot simply be avoided with skilled crisis prevention. At the same time interventions must be safe and

appropriate to the child, the situation and to the overall plan of care. While agency managers determine which interventions are approved, the case manager and care team including the parent/guardian of the child determine specific interventions for a particular child.

Two important components of treatment interventions are to build upon strengths and to address the deficiencies of each child. When possible building upon strengths can be the most potent agent of change. Jasper Mountain has multiple treatment components that build upon strengths particularly where staff 'catch' children doing well and not just seeing problems. Some of the strength based components include: therapeutic recreation, the gemstones, equestrian program, arts and crafts, and much more. Addressing the causes of deficiencies of children must include addressing emotional and behavioral issues using the Jasper Mountain approach of changing the child from the inside out. For example, evidence based practices for trauma treatment must include re-exposure to issues that can cause emotional and behavioral reactions. If the issues that produce emotional tension and serious behavior problems are carefully avoided, then serious behavior will likely return within the family and community settings, where adults may not be prepared to respond safely and effectively. It is important to know how to prevent a crisis, but it is not always clinically optimal that all treatment enhancing situations of this type be avoided or prevented. The Agency does collect data on physical interventions, but we do not do this only to reduce the frequency of such events. Simply reducing as many physical interventions as possible ignores the responsibility of treating and changing, and not just temporarily preventing, problem behavior.

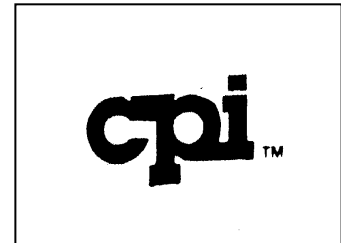
The purpose of residential treatment is to help each child achieve his/her individual treatment goals in the most expeditious way possible while using the interventions which would be most helpful for each unique situation. Clinically appropriate interventions, therefore, are not good or bad--they are effective or ineffective. Saying that one form of intervention in all cases is better than other forms is to not understand the purpose of a treatment program. The Agency is committed to reducing all unnecessary and non-therapeutic interventions, including, but not limited to, containment holds. But given a treatment center's goal to help each unique child within its care, it is important that the staff have the latitude to use all interventions that are safe and clinically appropriate, given the needs of each individual child.

CLINICALLY APPROPRIATE INTERVENTIONS

This section will begin with saying what interventions are not appropriate for use at Jasper Mountain. Mechanical devices used as restraints are never used, and the Agency does not believe in the concept of seclusion rooms for isolating traumatized children. Children may need to be removed from the presence of other children if they are being physically or verbally abusive to others, but children temporarily removed from other

children due to serious behavior are to be supervised and in the presence of staff and not left alone.

In addition to these exclusions, no type of punishing, harmful, painful or punitive interventions are appropriate in the Agency's treatment programs. Specifically, the Agency prohibits degrading punishment, corporal or physical punishment, painful aversive stimuli, forced physical exercise, punitive work assignments, group punishment for one person's behavior, medication for punishment, mechanical restraints, extended isolation without contact with peers or staff, depriving children of food or other basic needs, and preventing contact with family members when contact is not prohibited and a part of the treatment plan. The Agency also does not permit the use of chemical restraint to control serious behavior. All physical interventions used are within the guidelines of the State of Oregon's approved crisis management system – Crisis Prevention Institute or CPI.



In contrast, the array of the Agency's approved interventions will be described in the next sections, including verbal, non-verbal, chemical, physical and environmental. Of these options, physical interventions will receive the most attention, but this is not because they are the preferred intervention. Rather, it is because most educational settings, college courses, and training programs cover verbal interventions effectively, and staff members coming into a treatment program are generally much more knowledgeable about verbal and non-physical interventions than physical ones. In addition, the modern climate of mental health services seems to focus largely on limiting or eliminating physical interventions. Consequently, it is important that staff be educated regarding the clinically appropriate reasons for including physical interventions in the treatment setting, and the ways to use such interventions both safely and effectively.

COGNITIVE RESTRUCTURING INTERVENTION

A Research Based Method of Treatment and Behavior Management

The Agency does not agree with the management approach known as a "time-out" due to its punitive nature (the child is sentenced to an amount of time for some wrongdoing). Instead, the Agency uses an approach that promotes changes in the way the child's brain responds to situations the child encounters. This approach is called Cognitive Restructuring.

Cognitive Restructuring (CR) is a method to retrain the brain of children who experience the chronic affects of trauma and/or emotional disturbances. Briefly stated, CR aids the child in moving from neurological patterns of "fight or flight" toward new patterns of higher order reasoning and executive functions taking place in the brain.

This method can be used anywhere and anytime and can have immediate as well as long-term positive implications for a child's recovery and social success.

Cognitive Restructuring is supported by years of brain research that identifies the neurological region of the brain housing the fight or flight response of the limbic system, specifically the amygdala. The amygdala is the fear center of the brain. It is activated by intense stressors in life in the short-term, and is chronically activated by significant traumatic experience. Brain research also identifies the higher reasoning centers of the brain housed in the neo-cortex and specifically in the pre-frontal lobes of the brain. These are the regions of executive functions such as: planning, thoughtful consideration, cause and effect, delaying gratification, inductive and deductive reasoning, and many other essential thought processes. Stated briefly, traumatic experience produces a reactive fear-based response to new stress. Cognitive restructuring helps the child reduce fear and reactivity and encourages better use of cognitive skills resulting in pro-social behavior. Research has shown that the brain adapts with new neuro-templates with repetition. As with any skill, CR takes practice and repetition; therefore the more this skill is practiced, the stronger it is imprinted into neuro-pathways in the brain.

In a way, CR is the primary process of all trauma and rehabilitative therapies. This process moves an individual from being a reactor to an actor, from someone who is victimized by the world to someone who successfully negotiates through the challenges of life. Cognitive Restructuring can be explained in complex neurological terminology or in easy to understand practical terms. The practical description above forms the basis for effective behavior management approaches to children who are reactive, impulsive and appear unable to think through challenges in life.

The Three "R"s - As a behavior management approach, CR provides the child with what is missing in their life—training in full use of their own brain power. A child at any age can learn the quick and easy steps to CR. These steps have been described as the three "R"s—Relax, Rethink, and Respond. These easy to remember steps can help both the child and the adult to remember the important components of CR training of the brain.

Relax - recent evidence based research indicates that among the most powerful interventions for multiple types of emotional disturbances is training in relaxation. This step not only can immediately change cognitive functioning and move the child from processing in the limbic system to the neocortex, but it also can have an immediate calming influence on behaviors and emotions. Hundreds of methods of relaxation have been studied and essentially all work if they reduce autonomic arousal, reduce blood pressure, and reduce reactive stress. Easy methods have been taught to children for decades such as: count to 10, take several deep breaths, close your eyes and go to a calm place you have been before, or many other similar approaches.

Rethink – after some relaxation has been achieved, the brain is more available to use higher reasoning centers. For this step the child will usually need outside coaching at first to see possibilities other than habitual negative reactivity. As a practical step this involves the adult helping the child think about the situation--what has happened, what choices the child has for potential responses, and what alternatives might produce better outcomes than others – therefore helping the child use thoughtful consideration and better understand cause and effect or the results of decisions the child makes. This assistance from staff encourages the child to use reasoning centers of the brain.

Respond – only when the child is using higher order thinking can he or she see the alternative to negative reactive behavior; that is, to respond to the situation in a way that will result in positive outcomes. The ability to respond rather than react is the key to regaining self-regulation, the lack of which is the most pervasive result of childhood trauma.

The most helpful aspect of the three “R” process for the child is not how well they learn at any one time, but how often they engage in this process. Each repetition results in real changes in the brain, real stress reduction, and real experience at internal personal power to change the world that the child has previously experienced as overwhelming and more than the he or she can cope with.

The CR process and intervention will be as effective as the adult using it. The fundamental steps include the three “R”s with the connection, assistance, and encouragement from the adult. This is not a process the child can do alone, or they would have done so in the first place.

There is one more “R” that is critical in this process and that is “Repetition.” It is in repetition that new patterns of behavior are developed and more importantly that new neuro-pathways change the structure of the brain, subsequently optimizing the executive functions that provide the child with the building blocks of social and personal success.

VERBAL INTERVENTIONS

Clinicians usually rely heavily on verbal communication because they are most comfortable interacting on a verbal level. Training programs for therapists stress what is said to a client more so than any other form of communication. With preadolescent children, however, verbal therapies and interventions are often not as effective as other forms. In fact, one of the most important principles to understand concerning verbal communication with children, is actually its limitations. Limitations may include a child’s limited receptive language skills, difficulty understanding the verbal communication of adults due to neurological stress reactions, and many other limitations such as the difficulty some children have understanding the real meaning of

verbal messages or hearing all, and not just some, of what is said. It is important with young children not to overly rely on words.

This being said, verbal interventions are still a critical aspect of an effective treatment program. The basic verbal skills of communication such as active listening skills, attending behavior, tracking, reflection, summarization and many others are important for all Agency staff to be familiar with. These verbal skills will be taught in agency trainings but will not be covered here. However, staff should be cautious not to overly rely on verbal interventions to teach, to counsel, to calm down, to provide reassurance, or to facilitate various aspects of socialization. Words can be powerful in some treatment situations, but they are only one way to intervene.

NONVERBAL INTERVENTIONS

Words are less than 25% of any interchange between people. Facial expression, posture, tone, cadence, volume, gestures and other components of communication add to the full meaning of words. Children are particularly sensitive to nonverbal messages, as they have learned to read nonverbal messages from their caretakers long before they could understand verbal messages. Due to previous abuse many children are hypersensitive to nonverbal messages and may completely miss what is being said. Most children in treatment settings have also refined their ability to have the words of adults, “go in one ear and out the other.” An effective clinician, therefore, will need to know how to use nonverbal communication to achieve therapeutic goals. Most educational programs in the field of social sciences will cover nonverbal



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communication. In a residential treatment setting, these skills will be further developed through experience and awareness. Staff should remember that actions do speak louder than words in treatment settings, as well as in homes and schools. Children will primarily learn by watching the modeling adults demonstrate. How a staff person handles feelings, conflicts, and frustrations is far more important than what that staff person tells a child about these things.

CHEMICAL INTERVENTIONS/THERAPEUTIC MEDICATIONS

Physical interventions are not the only controversial topic in treatment approaches. Some programs have a philosophical leaning toward the use of chemical interventions, and some lean away from their use. Jasper Mountain takes no position promoting or discouraging the use of chemical interventions, other than not permitting chemical restraint. When a child has serious behavioral problems, chemical restraint and mechanical restraint are never allowed. Regarding other uses, however, the Agency

does take the position that if a chemical intervention can safely facilitate treatment progress for a child, it will be considered. External progress must always be weighted with empowering the child to make internal gains as well. If a chemical intervention is chosen, the best approach is to effectively take advantage of the intervention by using a therapeutic dosage and not to over- or under-medicate. Medications should be linked with encouraging the child to make internal changes and demonstrate self-regulation.

Specific decisions concerning the use of therapeutic medications are made by the psychiatrist and the family with consultation from the treatment staff. Although the psychiatrist determines the medication, a basic knowledge of chemical interventions by treatment staff will also enhance the effectiveness of this intervention. Psycho pharmacology is an extremely complex area of medicine and physiology, but even so, all treatment staff should expose themselves to the Agency's training materials, and develop a basic understanding of how medications work on the brain and how specific medications affect behavior.



PURPOSE OF PHYSICAL INTERVENTIONS

The first language of the child is touch. Research has shown the critical importance of basic human touch to physical growth, cognitive development, and personal and social attachment. Because touch is the primary language of children, treatment programs for young children that do not use touch or that take a "hands off" approach are missing many therapeutic opportunities. An effective treatment program will use touch as a potent means of communication and teaching.



Physical interventions include any situation where there is a therapeutic gain possible through physical touch.

Physical interventions, therefore, are not restricted to intervening with an out-of-control child. Physical interventions include any situation where there is a therapeutic gain possible through physical touch. Depending upon the situation, this might include a hug, a back rub, a hand on a shoulder, sitting close to a child, giving a child a piggy back ride, having a child sit on your lap, or holding a child's hand or a host of behaviors nurturing parents use with their children. Too often people think of physical interventions as negative interactions when there are problems. At times the lack of physical touch may actually promote a crisis in a child with emotional disturbances. It is often the case that the types of

interventions mentioned above can also help desensitize a traumatized child to negative association with physical touch from the child's past. Desensitizing negative reactions

to touch in traumatized children is a recognized evidenced based method in treating post trauma reactivity and anxiety disorders.

As stated earlier, in the controlled setting of a treatment center, not all emotionally laden issues and situations that might bring out intense reactions and behaviors (which some would call a crisis) are to be prevented. The role of the treatment center is to accomplish the treatment goals of each unique child. To borrow from an investment commercial, at Jasper Mountain, “we measure success one child at a time.” It would be a failure for a treatment center to graduate a child who with the assistance of trained staff has avoided situations that precipitate antisocial reactions—reactions which then would come out at home or in school after leaving the tightly controlled setting.

Despite some people who believe otherwise, the Agency’s position is that clinically appropriate physical interventions are not negative, punitive, nor a symbol of failure on the part of either the child, the family or the staff person. As such the organization does not take steps to reduce or eliminate approved interventions. Rather, the Quality Assurance Committee and Management Team both work to reduce or eliminate interventions with little or no therapeutic value among the interventions that are approved by policy. Non-therapeutic interventions are first identified by shift leaders, then program staff who review all incidents, then by program directors and finally by the Management Team. When an intervention is deemed to be ineffective or lacking in therapeutic value for a specific child in a specific situation, additional training is provided to the staff and new instructions are developed for the staff as a whole including changes in the child’s behavior management plan. The Executive Director in consultation with agency crisis trainers reviews the national literature for emerging themes in behavior management. Agency trainers also receive information from our crisis intervention system, CPI. The organization also participates in information exchange with theory and practice regarding behavior management.

Fundamentally the organization bases its position on behavior intervention with the acknowledgement that children need physical touch and they need tangible reminders that a competent and caring adult is working with them. Emotionally disturbed children need these reminders more than other children. National research indicates that young children, such as those in our programs, more frequently have violent behaviors than older adolescents. When used in the right way and at the right time, physical interventions can be some of the most potent aspects of a clinical regimen, particularly in the early stages of a child’s residential stay.

In summary, there are a variety of reasons to physically intervene with a child in a treatment center. Physical touch is one of the basic needs of every child. All these reasons can be consolidated to say that a physical intervention is designed to let a child know that you are there, you are prepared to handle any problem, and the child is safe and in good hands. Your presence in these ways constitutes safety and

predictability for the child—these are the most basic human needs and rights for all children.

TYPES OF PHYSICAL INTERVENTIONS

Before discussing specifics regarding more restrictive physical interventions, it is important to emphasize the Agency's concept of being "firm and friendly." According to our program philosophy, the balance of firmness and caring is important to avoid manipulation by the child (firmness), and avoiding the perception of punishment (friendly). This does not mean that a staff person can be both firm and friendly in every situation simultaneously. Many situations do not allow this. It does mean that overall a staff member must be able to establish a relationship with a child that is characterized by firmness (or the staff will not be respected or taken seriously), and friendliness (or the staff will be viewed as another punitive adult in the child's life). For most physical interventions, if the intervention is both firm and friendly, the staff member will come out ahead and so will the child.

Behavioral redirections that are used before a containment hold: There are many interventions using supportive physical touch that can help calm a child or deescalate a child's emotions and behaviors. Many of these have been mentioned: touching a child's arm or shoulders, holding his/her hand, and other uses of supportive touch and close physical proximity to the child. When this is done in the right way and at the right time, it can answer the questions behind a child's testing behavior and can at the same time be very reassuring to the child. At a later time many children can admit that it was good to know that the adult set limits and then acted to enforce those limits. In translating the meaning of a child's behavior, do not overlook the obvious. If a young child knows that a certain violent behavior will end up in an adult physically preventing violent behavior, there is a good possibility that the child wants to be reassured by the adults physical touch. Children are not always testing when they act in a way that is unsafe. At times they may have reached their limit to be able to handle the emotional demands of a situation and begin to act in violent or other hurtful ways either to themselves or others. When a child becomes violent, immediate steps must be taken to contain the potentially dangerous results. This is one of the most critical times for a traumatized child to hear, see, and feel the reassuring protection of an adult who is acting in the child's best interests.

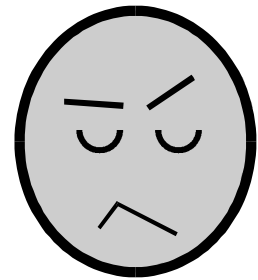
An intervention that has not yet been discussed is the need at times to physically move a child from a situation that may escalate into a safety concern. Young children may need to be physically moved when they do not perceive the danger in a situation. Older children may need to be removed from a situation where the child is intimidating another child or is being intimidated. There may be a variety of situations where a staff person may need to have a child move from or to a different setting. If a child has developed a habit of running from adults into unsafe situations, the adult may need to physically prevent this unsafe behavior. The behavior of some children may present a

risk to other children. It is important to consider all factors in situations that may require a staff to intervention in a physical way to insure safety with the least restrictive methods possible. The child's behavior management plan should identify the special intervention needs of the child. The behavior management plan is written by the program manager or assistant with input from intake information, the parents/guardians, care team, therapist and psychiatrist. The behavior management plan includes information about the child's history, primary problems, interventions that have been effective and ineffective, special treatment procedures approved and not approved and recommended interventions for the specific child. Behavior management plans are agreed to by the parent/guardian and are reviewed monthly and revised when necessary by the therapist and care team for the child.

When situations arise where there is a need for a child to move from a location, staff are to use crisis prevention training to accomplish this. First, verbal skills should be used and the child provided the opportunity to cooperate with staff. If the child does not voluntarily comply then the staff could provide choices to the child that may involve consequences for lack of cooperation. If the child needs further encouragement the staff could use humor, holding the child's hand, or putting a hand on the child's shoulder in a supportive way. Consistent with federal and state statutes, if more than limited physical force is needed to maintain safety in the situation and the physical intervention involuntarily restricts the child's movement, then the intervention meets the definition of a containment hold. To move to a containment, the actions of the child must constitute a danger to self or others.

Containment holds: In addition to the interventions mentioned thus far, there are interventions of a more firm physical nature. State of Oregon administrative rule 309-032-1505 defines "personal restraint" the same as the Federal definition, "the application of physical force without the use of any device, for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm. Personal restraint does not include briefly holding without undue force an individual to calm or comfort him or her, or holding an individual's hand to safely escort him or her from one area to another.) Federal regulations (42 CFR 483.352) define a restraint as, "the application of physical force without the use of any device, for the purposes of restraining the free movement of the resident's body. The term personal restraint does not include briefly holding without undue force a resident in order to calm or comfort him or her, or holding a resident's hand to safely escort a resident from one area to another." All physical interventions that fit within these definitions, which the Agency refers to as a containment hold, will follow Agency, State and Federal guidelines, and will be authorized by the treatment plan and documented in an approved manner. Interventions used in the agency are to be consistent with the Crisis Prevention Institute (CPI). Additional policies on physical interventions to meet the Federal Department of Health & Human Services rules (42 CFR Part 483 Subpart G), can be found in 2.A.5. "Special Treatment Procedures."

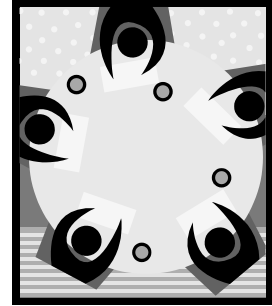
For our Agency purposes, the term “restraint” is not the best of words. It means something mechanical to many people. In our setting a restraint is actually a therapeutic hold used to partially or fully contain the child to prevent potential harm to self or others. Such restraints usually involve containing the child’s body, arms, and legs, all of which are most frequently used by young children to be violent to self or others. Since the child is either being violent to self or others, the child usually responds to being restrained by resisting or seeing if you have control of the situation. Once these violent children find that you have control of the situation, they often see if they can emotionally be more powerful than you, as they have been over other adults in their past. This striving for power often takes the form of screaming, head butting, verbal insults or yelling that you are hurting them and you are therefore a child abuser. For many of the children coming into our programs with violent pasts, they will often need to go through this testing before they see that in this situation the adult can manage their violent behavior and be in control of the situation by preventing the child or anyone from being hurt. For many emotionally disturbed children, only after all this testing has occurred can they begin the steps of moving beyond the violent and controlling behavior that hides their fear, sadness and pain. If a staff person and a treatment program cannot get to the place of reassuring protection, the therapeutic work will often not occur.



Containment holds are only appropriate in emergency situations where there is an inherent threat of harm. Based upon this threat the goal of the intervention is to prevent immediate harm to the child, to others in the environment or serious threats of violence that are likely to result in harm. When a containment hold is necessary, it is essential that the staff are as calm as possible to handle the situation wisely and with the least amount of physical force necessary. The staff need to send a signal to the child that the potentially violent situation is under control. It is critical to abused children that, during holds, the child is treated appropriately and respectfully or they could link you with past abusers. During the hold the staff are to insure the safety and well-being of the child including physical and psychological well-being. It is important that the hold not involve physical pain or interfere with respiration. The child’s psychological state is also to be monitored by the staff involved and any concerns are to be immediately reported to the hold authorizer and the shift leader. Respectful treatment of the child must be modeled if the child is expected to act respectfully in return. It is also important that the child experiences that he/she has dignity and rights that will not be violated. It is important to remember that the child’s first right is to be safe.

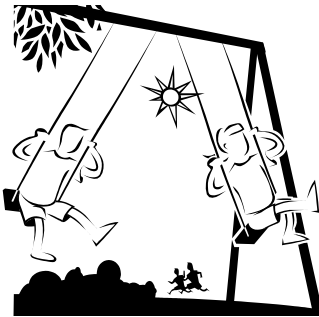
Monitoring of Behavior Management Practices. In addition to extensive training, the Agency uses several methods to additionally insure safe, effective practices in the area of behavior management. Agency programs compile data on therapeutic holds. This

information is reviewed on a monthly basis by the Quality Assurance Committee. The Board of Directors receives a program report each quarter that addresses the use of behavior management practices within the agency. In addition, the Management Team annually reviews the agency's use of behavior management practices to insure compliance with State and Federal law as well as safe, effective practices for treatment programs. Other principles of management and discipline will be addressed specific to individual children and in staff meetings and trainings.



ENVIRONMENTAL INTERVENTIONS

It is a fundamental belief of Jasper Mountain that the most potent influence on children is the synergy of all aspects of the child's environment. This environment is composed of the atmosphere, the architecture, the people, the lighting, the sound, the activities, the relationships and all other components that interact and interplay to form the treatment environment. Considerable energy has gone into the physical qualities of Agency programs. To develop the optimum impact of environment as an intervention, it is



important to understand the effect of all the aspects of a child's life, and how they create a positive or negative influence. In the final analysis, our programs will succeed or fail not on the basis of individual therapy, medications, skilled verbal or physical interventions or any other single aspect of the program. It will be the overall environment that will promote or delay the child's progress toward an integration of their overall health and personal and social development.