



**Residential  
Treatment  
Center**

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**EMPLOYEE TRAINING MANUAL**

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*revised 02/25/05*

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# 1

## TREATMENT PROGRAM

### Introduction

The Youth Focus Residential Treatment Center (RTC) is a 12-bed intensive therapeutic placement for young people between the ages of 12 and 17. The facility provides an unlocked, coed setting affording a moderate level of structure and security to its residents. In providing a longer length of stay than is currently feasible in hospital settings, the RTC/PRTF program offers an intensive therapeutic focus that strives to address the core of a young person's problems in an effort to provide a lasting solution to the difficulties with which they are struggling.

### Treatment Philosophy

The treatment program at the Youth Focus Residential Treatment Center is dedicated to enhancing the psychological, emotional, and interpersonal functioning of its residents. Efforts to help residents modify dysfunctional behaviors and to teach improved coping skills are accompanied by an emphasis on accepting and respecting residents as individuals with diverse backgrounds, interests, and abilities. By using positive feedback and encouragement in a non-coercive manner while minimizing the use of punishment, the RTC program helps residents grow into healthy, adaptive individuals with a capacity to appropriately manage themselves and to use non-destructive means to deal with their conflicts and frustrations.

In learning to identify maladaptive thoughts, feelings and behaviors, residents come to understand and anticipate the consequences of negative choices and learn to replace these with more effective and lasting solutions to their problems. Residents thereby learn to avoid self-defeating styles of responding to the demands and expectations of their environment. Through the teaching of coping and social skills and by guiding residents to develop alternative ways to handle their difficulties, the program encourages residents to develop a strong, healthy and adaptive sense of self-confidence and self-esteem. In teaching residents appropriate verbal and non-verbal expression of feelings, the program helps affirm and enhance the resident's sense of self-control and optimism.

Building on the strengths and resources of young people, the RTC program encourages the development in residents of a positive value system and a sense of responsibility for themselves and their community. By instilling values and helping residents learn to care for themselves and their community, the RTC program helps residents to become constructive citizens and to achieve their highest potential. Residents are encouraged to be honest, to accept personal responsibility for their behavior, and to support their peers in doing the same. In doing so, residents come to demonstrate respect for themselves and others, and grow in their capacity to care about other people and the community.

The Residential Treatment Center utilizes a multidisciplinary treatment approach. Team members include a clinical psychologist, counseling therapist, recreation therapist, consulting psychiatrist, education specialist, dietary consultant, residential care supervisors, and mental health technicians. The behavioral level system provides a balance between management of maladaptive behaviors and graded opportunities for residents to practice independence and responsible autonomy. The environment of the RTC is designed to provide a supportive and therapeutic structure, while helping the residents to take an increasing degree of responsibility for their actions and activities. Each resident's treatment plan is individualized and goal-oriented, taking into account each individual's age and developmental level, strengths, and weaknesses.

Residential treatment at the Youth Focus RTC is provided within a 24-hour per day, year-round treatment model, which emphasizes the resident's rights to self-determination as to what Youth Focus service they make application for. A brochure detailing the full spectrum of Youth Focus services available to youth and their families is available to members of the public at the RTC facility location, or can be obtained by contacting the RTC at (336) 375-8333.

## **Individual Therapy**

Individual psychotherapy is conducted during treatment a minimum of once weekly. These private sessions with a therapist provide an opportunity for the resident to examine their methods of handling feelings and problems in their lives, to try out new ways of behaving and coping in their relationships with others, and to deepen their understanding of their own selves as persons. Individual therapy sessions provide opportunities for the young person to privately discuss their problems and to develop more adaptive ways of handling them. When a resident experiences difficulty or conflicts during the course of their day, the individual therapist will often be available to meet with the resident to process the events and help in problem solving. In many cases, this process will facilitate the resident's efforts to identify and understand their own feelings and reactions in the midst of the crisis, and help the resident generate

an adaptive and healthy resolution to the situation. Over the course of residential treatment, individual therapy fosters the ability in the resident to resolve their problems with greater independence and less direction and guidance from the therapist.

## **Family Therapy**

Whenever possible, efforts are made to ensure that the residential treatment remains family-centered throughout the resident's stay. Therefore, treatment participation by the resident's family or support system is mandated whenever possible. The frequency of family therapy sessions may vary depending upon the individual treatment plan and the family's geographic distance from the treatment center. Family therapy is required a minimum of once monthly, occurs more frequently whenever possible, and is available on a weekly basis when feasible for the family.

Family therapy provides an opportunity to discuss family problems and issues and to explore how these problems affect each family member. Early in the RTC stay, an emphasis is placed upon engaging the family members in the resident's treatment, maintaining regular participation by the family, and enhance the relatives' understanding of the resident's behavioral and emotional difficulties. The therapy works toward providing new avenues of positive, healthy, and enjoyable interaction between the resident and their family members. As the resident and the family make progress toward accomplishing their treatment goals, the emphasis shifts toward empowerment of the family, reunification of the resident with the family, and a successful return of the resident to the home. When circumstances do not allow for placement with the family upon discharge, family therapy work will facilitate successful adjustment to further out-of-home treatment or placement.

## **Group Psychotherapy**

Residents participate in group psychotherapy a minimum of two times each week. Group Psychotherapy provides an opportunity to explore group dynamics, interpersonal relationships, and patterns of behavior and perception in social situations. Group Psychotherapy encourages the development of an increased understanding of self and others, and facilitates the development of healthier patterns of social interaction among residents.

## **Recreation Therapy**

The Recreation Therapy program consists of recreation therapy groups, occupational therapy groups, and enrichment groups that focus on assertiveness training, anger

management, leisure skills, cooperative games, social skills, exercise, and arts and crafts. Recreational Therapy provides a therapeutic recreational program that is adapted to the capabilities and needs of each resident. This therapeutic activity program may include off-campus activities.

## **Education**

The Youth Focus RTC School program provides educational services to our residents year round. An education specialist who holds North Carolina Teacher's Certification provides these educational services, while the RTC school program carries North Carolina certification as a licensed non-public school. Services include providing patients with an ongoing individual education program designed to meet the specific academic, social, developmental and emotional goals set for each patient. Education services are designed to meet the treatment needs of the resident and to provide continuity in the educational process during the course of residential treatment.

## **Milieu Therapy**

The Youth Focus RTC employs a level-based milieu system designed to facilitate growth and therapeutic progress in all residents. Within this level system, the expectations placed upon each individual are linked to their current level of functioning. The level system rewards children and adolescents for healthy efforts made in treatment, while discouraging unhealthy, self-defeating, or antisocial behaviors. Each successive level in the system encourages the resident to assume more responsibility, independence, and maturity. This program for adolescent residents facilitates the maintenance of an optimum rate of development and the successful achievement of age-appropriate developmental milestones, and provides the framework within which the individualized treatment plans are implemented.

## **Psychiatric Consultation**

A state-licensed Psychiatrist provides medical consultation on a weekly basis. This coverage includes regular monitoring of the medication currently prescribed for residents, and consultation with RTC staff regarding the psychiatric status and treatment progress of residents. If a resident comes to the RTC with an ongoing treatment relationship with a psychiatrist in the community, the RTC psychiatric consultant provides ongoing communication and consultation throughout the resident's stay as a means of preserving that relationship and ensuring continuity of

care across the treatment spectrum. Trained Youth Focus personnel working at the RTC will administer prescribed medications during the resident's tenure at the facility.

# 2

## ADMISSION INFORMATION

### Referrals

Referrals to the Youth Focus Residential Treatment Center may be made by physicians, mental health professionals, parents, juvenile courts, and other residential and acute care inpatient facilities. The Youth Focus RTC will screen referrals for the appropriateness of residential placement prior to admitting the young person. Information from previous treatment (such as developmental and social histories, treatment summaries, psychological testing results, and medical history and physical exams) should be forwarded to Youth Focus at the time of referral for the purpose of this screening. Referrals may be initiated by contacting the Youth Focus RTC at (336) 375-8333.

### Criteria for Admission

In order to be considered for admission, a young person must be:

- ◆ engaging in a persistent pattern of disruptive or potentially harmful behavior,
- ◆ exhibiting persistent disturbances in age-appropriate adaptive functioning and social problem solving, and
- ◆ exhibiting disturbances in their psychological functioning.

Additionally, referrals will be screened to ensure that treatment at the RTC represents the least restrictive placement alternative for the young person at that time.

### Fees and Insurance

Staff members at the Youth Focus RTC are available to explain charges and fees and to discuss final policies prior to admission. Residential treatment is available at the Youth Focus RTC at a rate of \$510 per day. Pre-certification of residential treatment may be necessary to confirm insurance coverage and method of payment. Indigent care at the RTC may be accessible upon request pending the availability of

relevant funding. Inquiries regarding fees for treatment and clinical pre-certification should be directed to the RTC Unit Manager at (336) 375-8333. Further clarification of policies regarding fees, charges, or payments may be directed to the Youth Focus business office at (336) 274-5909.

## **Visitation**

Residents are allowed to receive approved visitors during reasonable hours. The RTC staff reserves the right to supervise or terminate visits if doing so is deemed necessary due to the behavior of the resident or visitor. Visitors are encouraged to schedule visits in advance. Regular visiting hours are Monday-Friday, 6:00 to 7:00 p.m. and Saturday-Sunday, 1:00 to 4:00 p.m. Other visiting times may be arranged through the resident's primary therapist or with the Residential Care Supervisor on duty.

## **Telephone Calls**

Residents may place and receive telephone calls using the unit telephone located at the staff workstation. Outgoing calls may be earned by residents through the unit level system, while incoming calls from individuals who have been authorized by the resident's guardian are unrestricted. Residents may not place calls for other residents. Most calls must be limited to 10-15 minutes, as this ensures that other residents may have access to the telephone. Residents may place their telephone calls on Monday through Friday from 11:30 am - 12:30 p.m. and 7:00 p.m. - 8:30 p.m., and Saturday and Sunday from 1:00 p.m. - 4:00 p.m. and 6:00 p.m. - 8:30 p.m. If parents give their child a telephone credit card, the parents are responsible for the bill. However, it is not recommended that the residents have such credit cards due to the possibility of unauthorized use. Inappropriate behavior (such as swearing or yelling) may result in termination of the call by RTC staff.

## **Therapeutic Passes**

Therapeutic passes may occur throughout the resident's treatment as a function of their progress toward achieving therapeutic goals and their ability to participate in such passes in a responsible, safe, and productive manner. Therapeutic passes always include preset goals that relate to the resident's ongoing work in individual and family therapy. While the duration of therapeutic passes will vary according to the needs of each resident, passes may typically range from a few hours up to three days in length. Passes may be arranged with family members, agency personnel, or other responsible adults as approved by the adolescent's guardian and the RTC Clinical

team. Scheduling of therapeutic passes may be accomplished by contacting the resident's primary therapist in advance.

## **Mail**

Residents may send and receive mail during their tenure at the Youth Focus RTC. However, the RTC Clinical Team reserves the right to monitor the opening of mail to screen for contraband (see below). It is prohibited to join clubs to purchase books, tapes or CDs at this address. The Youth Focus staff must approve magazines and catalogs received while residing at the Youth Focus RTC.

## **Meals**

Residents eat cafeteria style in the Youth Focus RTC dining room. Dietary consultation is available for those with special needs. Occasionally, special meals are prepared on the unit or on cookouts by the residents. Residents may not store food in their rooms. Snacks and drinks may be made available in the RTC day room at staff discretion.

## **Family Participation**

Family members are expected to participate in family therapy and to attend and participate in regular treatment planning meetings whenever possible. In the interest of the safety of the residents at the RTC, family members are expected to abide by all rules and regulations of the RTC when visiting the facility. Family members are expected to keep the RTC staff or the resident's primary therapist abreast of any significant events or information relating to the resident or to the family.

## **Expectations of Residents**

The Youth Focus RTC strives to foster an environment of mutual respect and responsibility within the treatment program. Residents are therefore expected to display respect for themselves, staff and peers at all times. This includes refraining from the use of profanity, threats, and aggression while in the facility. Residents are expected to demonstrate respect for property belonging to themselves and others. Careless or willful damage to or destruction of property will result in a charge for the repair or replacement of the relevant article. Lending, borrowing or exchanging items among residents is not permitted. Residents may not possess any contraband materials (see below) while at the treatment center. Residents are responsible for attending and participating in all daily groups and activities, and are expected to follow

all unit rules and comply with staff requests. Residents are expected to maintain good personal hygiene, to do their own laundry, and to keep their room and common living space neat and clean. Residents are expected to get sufficient sleep at night so they will be alert for school.

## Personal Items

The following list includes some of the items you may need to bring with you to the RTC. All clothes and personal items should be marked with the resident's name.

- ◆ Enough casual, in-season, comfortable clothing for 5 to 7 days (i.e. jeans and T-shirts, sweat suits, shirts, skirts and shorts of reasonable length)
- ◆ Underwear sufficient for 5-7 days
- ◆ Comfortable socks, shoes, and sneakers
- ◆ Pajamas, nightgowns, bathrobe, appropriate for mixed company
- ◆ Sweater or jacket
- ◆ Personal hygiene items such as a toothbrush, toothpaste, shampoo, conditioner, plastic comb, brush, hair dryer, curling iron, cosmetics, feminine hygiene products
- ◆ Wind-up or battery operated alarm clock
- ◆ A modest bathing suit
- ◆ Stationary and stamps
- ◆ No more than 5 to 10 dollars spending money

Residents are encouraged to bring their own blanket, comforter or pillows. Washers and dryers are available at the facility, so clothing for more than 5-7 days is unnecessary. Fingernail clippers, disposable razors, and electric iron will be made available by the RTC staff and can be obtained at the staff workstation.

## Dress Code

Clothing is to be clean and neat at all times. Male residents must wear a shirt as well as pants and/or shorts outside of their bedroom. Female residents must wear either a dress or a shirt with pants, shorts or a skirt. Clothing that is too tight or suggestive is not allowed. Suitable nightclothes are to be worn for sleep. Thus, all residents are required to wear appropriate clothing to bed and remain clothed throughout the night. Residents are expected to be dressed appropriately before coming out of their rooms. Residents are expected to bathe daily and maintain a clean and well-groomed appearance. Bringing expensive clothes or jewelry to the RTC is discouraged due to the possibility of loss or theft. The Youth Focus RTC will not be

responsible for the loss of clothing or personal items that may occur during a resident's stay on the unit.

## Contraband

The following list includes some of the items that residents are NOT allowed to have on the unit. *The RTC cannot be responsible for any loss or damage of personal items.*

The following items are not permitted:

- ◆ Valuable items, especially those that cannot be replaced
- ◆ Large amounts of money, credit cards, checkbooks
- ◆ Cosmetics or personal care products that contain alcohol
- ◆ Glass or ceramic containers
- ◆ Aerosol cans
- ◆ Sharp objects (such as razor blades, safety pins, needles, etc.)
- ◆ Keys
- ◆ Wire clothes hangers
  
- ◆ Cigarettes and other tobacco products
- ◆ Matches, lighters, and other flammable materials
- ◆ Illicit drugs, illegal substances
- ◆ Drug paraphernalia
- ◆ Sexually oriented materials
- ◆ Weapons, including any form of knife
- ◆ Cameras and recording devices
- ◆ Personal items or clothing with writing or pictures suggestive of drugs, alcohol, sex, violence, the occult, or anything determined by staff to be inappropriate

All material brought into the RTC, including personal belongings, packages and suitcases are subject to safety searches by the staff. Electrical appliances such as radios, hair dryers and curling irons must be placed in a storage basket, where residents as needed may check them out.

## Orientation

Upon admission to the RTC, each resident will receive an assessment of their current problems and strengths, family background information will be gathered, and any necessary evaluations or tests will be conducted. A primary therapist will be assigned and will work with the resident and family members throughout the period of treatment. The primary therapist or the RTC treatment team will review the treatment program policies and procedures, will answer any questions and, if appropriate, will assign a more experienced resident to help the new resident adjust to the milieu

## Discharge

As the anticipated post-RTC placement affects the setting of individual treatment objectives as well as the anticipated length of RTC stay, discharge planning begins upon admission to the Youth Focus RTC. The resident, family, and any ages involved with the resident are encouraged to participate in the discharge planning process with the RTC treatment team. Measurable treatment goals are formulated for all residents upon admission, and successful accomplishment of these goals provides the primary guiding factor for resident discharge from the program. Other factors which may lead to discharge include the identification of a more appropriate placement or level of care for the resident during their stay, or failure of the resident to benefit from the range of therapeutic services offered at the RTC after a sufficient trial. Return visits to the RTC after discharge is typically discouraged as a means of facilitating aftercare and adjustment to the home and community. In some special circumstances, such visits may be permitted with approval of the RTC Clinical team.

# 3

## RESIDENT'S RIGHTS AND RESPONSIBILITIES

1. The Youth Focus Residential Treatment Center will not refuse to treat someone because of their sex, race, sexual orientation, religion, or because of a handicap unless that handicap prevents them from participating in the program.
2. You have the right to receive individualized treatment.
3. You and your parents/guardian have the right to participate in the planning of your treatment, and to be informed about your condition and prognosis.
4. You have the right to be treated with consideration, respect and dignity at all times.
5. You and your parents/guardian have the right to be notified in advance if you are going to have significant changes made to your treatment plan or if you are going to be transferred to another facility. You and your parents have the right to know why these changes happen.
6. You may not be transferred to another facility unless the other facility has agreed to take care of you and you and your parents have received a complete explanation of why the transfer is necessary and of what other options there are.
7. You have the right to choose how you will spend money given to you as allowance or earned through a job program, as long as law does not prohibit it.
8. You have the right to be safe from mental or physical abuse while you are a resident.
9. You have the right to have your opinions and recommendations considered for inclusion in the development and evaluation of the therapeutic program.
10. Physical restraining via therapeutic holding by staff can only be used to protect you from yourself or to protect others from you. Staff may place you in a room by yourself for your protection or for the protection of others. You have the right to the least restrictive conditions adequate for your care. Your parents/guardian may request to be notified whenever therapeutic holding or time-out is used in the course of your treatment.
11. Your parents/guardian has the right to refuse any specific treatment recommended by the RTC treatment team. The Residential Treatment Center reserves the right to

terminate the relationship with the resident upon reasonable notice, however, when such refusal does not permit adequate treatment by this facility.

12. You have the right to confidentiality in that confidential information gained through our personnel and treatment records not being shared with anyone outside of the facility without the permission of your parents/guardian, as is required by law.

13. You have the right to privacy in the care of your personal needs and possessions. However, if at any time during treatment it is suspected that you have drugs, alcohol, weapons or others dangerous items in your possession, you may be given a body search and your personal possessions may be searched.

14. You have the right to access information regarding your treatment plan while at the RTC. Requests for such information may be made through your assigned individual therapist.

15. Your parents/guardian has the right to be informed of the total costs and anticipated length of your treatment.

16. You have the right to be visited by your parents/guardian, family and other visitors while staying at the RTC, unless the treatment team determines that is not in the best interest of your treatment.

17. You have the right to receive private telephone calls from your parents/guardian unless the treatment team determines that is not in the best interest of your treatment.

18. You have the right to send and receive mail, unopened. However, incoming mail may be opened by you in the presence of a staff member to ensure that the mail does not contain any unauthorized, injurious, or illegal materials or substances. We can not hold mail or prohibit you from sending or receiving mail.

19. You and your family have the right to have an interpreter to help you talk to staff if you or your parents cannot speak English or are hearing-impaired.

20. If your visiting or telephone privileges are restricted, you and your parents/guardian have the right to have these restrictions explained to you. If restrictions are placed on your telephone or visiting privileges, the treatment team must reevaluate these restrictions every seven (7) days.

21. You have the right to refuse to talk with or see anyone who is not officially connected with the residential center or who is not directly involved in your care, unless it involves a legal investigation.

22. You and your parents/guardian have the right to be informed of all discharge and aftercare plans. You and your parents/guardian have the right to be informed by your doctor of any continuing health care needs you will have following discharge from the residential center.

23. You have the right not to be required to perform work for the residential center unless the work is a part of your treatment plan (such as cleaning up a mess that you have made). You are responsible, however, at all times for making your bed, keeping your room and possessions neat, orderly and clean, and helping to keep common areas of the residential center neat and orderly.
24. You have the right to wear your personal clothing and decorative items, as long as it is appropriate and these do not interfere with your treatment or with the treatment of others.
25. You have the right to privacy during interviews or body searches. This includes the right to have body searches performed by a staff person of your own sex and the right not to have to remain undressed any longer than is necessary for the body search.
26. You have the right to request transfer to another room if you are having difficulties with your roommate or if the room you are in is uncomfortable, unless it is contraindicated.
27. You and your parents/guardian have the right to know the name and profession of all the people involved in your treatment.
28. You have the right to be informed of use of tape recorders, audiovisuals, etc. during your treatment at the RTC.
29. You have the right to participate in religious worship.
30. You are responsible for being considerate of the rights of other residents and the rights of residential center staff. You are also responsible for being respectful of the property of others and the property of the residential center. You and your parents/guardian have the right to be told the residential center rules and regulations.
31. You and your parents/guardian are responsible for providing the residential center with your complete health history. You are responsible for telling staff if you are feeling ill. You have the right to prompt medical attention if you become sick.
32. You are responsible for following your treatment plan. You are also responsible for letting staff know if you do not understand your treatment plan or what is expected of you.
33. You and your parents/guardian have the right to voice your concerns or grievances and receive a response within a reasonable time period. You have the right to have this grievance procedure explained to you. You may access the proper grievance form at any time during your treatment, and may thereby file your grievance with the RTC Program Director.
34. You and/or your parents/guardian may file complaints with the Youth Focus Executive Director regarding your treatment. You and your parents have the right to be told how the residential center will deal with these complaints. You and your parents/guardian are encouraged to recommend changes in the residential program to residential center staff.

35. You have the right to contact the Governor's Advocacy Council for Persons with Disabilities (GACPD). This agency is designated under federal and State law to protect and advocate the rights of persons with disabilities.
36. You have the right to receive information necessary to give informed consent prior to the start of any procedure and/or treatment.
37. You have the right to be out doors daily unless the treatment team determines it is not in your best interest.
38. You have the right to be free from physical, chemical and mental abuse. Physical and chemical restraints may only be applied when ordered by your physician, and for a specific limited period of time, except when necessary to protect you from injury to yourself and others.
39. You have the right to contact and consult with, at your own expense, legal counsel, private physicians, private mental health, mental retardation or substance abuse professionals of your choice.
40. You have the right to a quiet atmosphere for uninterrupted sleep.
41. You have the right to access areas for personal privacy for at least limited periods of time unless contraindicated by the treatment team.
42. You have the right to decorate your own room following individual facility rules and without damaging Youth Focus property.
43. You have the right to dignity, privacy and humane care in the provision of personal health, hygiene and grooming care. Such rights shall include, but need not be limited to the:
  - (1) opportunity for a shower or tub bath daily, or more often as needed;
  - (2) opportunity to shave at least daily;
  - (3) opportunity to obtain the services of a barber or a beautician;
  - (4) provision of linens and towels, toilet paper and soap for each client and other individual personal hygiene articles for each indigent client. Such other articles include but are not limited to toothpaste, toothbrush, sanitary napkins, tampons, shaving cream and shaving utensil;
  - (5) bathtubs or showers and toilets which ensure individual privacy shall be available; and
  - (6) adequate toilets, lavatory and bath facilities equipped for use by a client with a mobility impairment shall be available.

# 4

## LEVEL SYSTEM

### Level 1

No requirements for maintaining level. To advance to Level 2 at the beginning of a given day, the following requirements must have been met on the previous day:

- ◆ at least 90 points earned
- ◆ no category 2, 3, or 4 infractions
- ◆ maintained any special precautions as specified by staff

### Level 2

**Entry Level.** Residents who are Level 2 and above are expected to accept responsibility for themselves and their behavior, and to be able to establish control over their own behavior when given guidance and direction by staff. To maintain this level, the following requirements must be met:

- ◆ at least 90 points per day

*Level 2 privileges are lost for 24 hours after any day during which point total falls below 90.*

To advance to Level 3 during weekly Peer Government meeting, the following requirements must be met::

- ◆ at least 100 points for 7 out of 7 days
- ◆ no category 3 or 4 infractions for 7 out of 7 days
- ◆ accumulate 1500 Level 2 points
- ◆ approval of Peer Government

### Level 3

Residents who are Level 3 and above are expected to be able to monitor their own behavior, to take responsibility for their own actions, and to correct behavior on their own. They should be able to recognize the impact their behavior has upon themselves and others and show an ability to adjust accordingly. To maintain this level, the following requirements must be met each week, and will be assessed during the weekly Peer Government meeting:

- ◆ at least 700 total points during the previous week
- ◆ at least 5 out of the last 7 days over 100 points

*Level 3 residents who fail to maintain requirements for their level will be demoted to Level 2 during the weekly Peer Government meeting.*

To advance to the next level during Peer Government meeting, the following requirements must be met:

- ◆ at least 120 points for 7 out of 7 days
- ◆ no category 3 or 4 infractions for 7 out of 7 days
- ◆ accumulate 2000 Level 3 points
- ◆ approval of Peer Government

### Level 4

To maintain this level, the following requirements must be met:

- ◆ at least 840 points per week
- ◆ at least 5 out of 7 days over 120 points

*Level 4 residents who fail to maintain requirements for their level will be demoted to Level 3 during the weekly Peer Government meeting.*

To advance, the following requirements must be met:

- ◆ at least 140 points for 7 out of 7 days
- ◆ no category 3 or 4 infractions for 7 out of 7 days
- ◆ accumulate 2500 Level 4 points
- ◆ approval of Peer Government

## Level 5

Level 5 residents are expected to monitor their own behavior and the behavior of others, and to assist others in accepting limits, following rules, etc. They are expected to be role models for other peers. To maintain this level, the following requirements must be met:

- ◆ maintain appropriate behavior
- ◆ no category 3 or 4 infractions
- ◆ must monitor own behavior
- ◆ discuss progress and behavior with staff on a daily basis

### Special consequences for Level 5:

- ◆ any category 1 or 2 infractions will result in the loss of 1 or more privileges as determined by the staff. Privileges can be earned back upon completion of appropriate tasks as determined by staff.
- ◆ abuse of any privilege results in the loss of that privilege for 24, 48, or 72 hours at staff discretion.
- ◆ any category 3 or 4 infraction will result in a level drop to level 1 for 24 hours with level 2 privileges earned back at the rate of 1 per day and additional levels earned back as determined by Peer Government.

**IMPORTANT NOTE: LOSS OF PRIVILEGES IN THE LEVEL SYSTEM IS NOT TO INFRINGE ON PATIENT RIGHTS, WHICH MAY ONLY BE RESTRICTED BY SPECIFIC ORDER OF THE TREATMENT TEAM**

## Privileges

*N.B.: The exercise of any privilege is subject to staff approval.*

### Level 1

- ◆ May have reading material in room
- ◆ May attend classes in school area at staff discretion
- ◆ May attend on-unit activities at staff discretion
- ◆ Bed time at 8:30PM

### Level 2 (Entry Level)

- ◆ All of the above
- ◆ Dining Room
- ◆ May vote in Peer Government
- ◆ May hold office of Secretary in Peer Government
- ◆ Use of dayroom and dayroom facilities during free time
- ◆ May keep personal radio in room
- ◆ Use of telephone to make 1 long distance personal call per week, 10 minute limit per call.
- ◆ Bed time at 9:30PM

### Level 3

- ◆ All of the above
- ◆ May attend off-unit activities at staff discretion
- ◆ Grounds - 15 minutes, 1 time per day with staff or Level 5 monitor
- ◆ Use of activity room and activity room facilities (Nintendo, etc.) during free time
- ◆ Room visitation, same-sex peers, both host and visitor must be at least Level 3
- ◆ May hold office of President or Vice-President in Peer Government
- ◆ May keep hygiene and other personal items in room with staff approval
- ◆ Use of telephone to make 2 long distance personal calls per week, 10 minute limit per call.
- ◆ Bed time at 10:00 PM Sunday through Thursday; 11:00 PM Friday and Saturday
- ◆ Eligible for Level 3 boys or girls outing and outing allowance
- ◆ Access to vending machines at staff discretion

#### **Level 4**

- ◆ All of the above
- ◆ May keep personal TV / video in room
- ◆ Grounds - 30 minutes, 2 times per day at staff discretion
- ◆ Off grounds - 30 minutes, 1 time per week with staff or Level 5 monitor
- ◆ Bed time at 10:30 PM Sunday through Thursday; 11:30 PM Friday and Saturday
- ◆ Use of telephone to make 3 long distance personal calls per week, 10 minute limit per call.
- ◆ May carry and complete own point sheet (must be initialed by appropriate staff)
- ◆ Eligible for Level 4 coed outing and outing allowance

#### **Level 5**

- ◆ No point sheet

*Any age appropriate privileges may be requested, but may require the approval of the RTC Clinical team, family, or others. All requests for special privileges should be made to the therapist, for example:*

- ◆ Individual activities
- ◆ Extended grounds or off grounds privileges
- ◆ Late bed times
- ◆ Preparing own meals on the unit

***ABUSE OF ANY PRIVILEGE RESULTS IN THE LOSS OF THAT PRIVILEGE EITHER ONE TIME OR FOR UP TO 24 HOURS, AT STAFF DISCRETION.***

## Examples of Infractions

The following are examples of undesirable behaviors that may result in consequences. They are divided into categories based on the severity of the infraction. This list is not all-inclusive, and serves as a guideline for the assignment of category. Assignment of categories for specific infractions is always at staff discretion.

### Category 1

- ◆ Inappropriate verbal behavior, i.e. disrespectful, rudeness, teasing, arguing, complaining, making excuses, loudness, sound effects, etc.
- ◆ Failure to report for medications on time
- ◆ Oppositional behavior, i.e. limit testing, threats to refuse to follow instructions, poor body language, slow response to directions, etc.
- ◆ Late for activities, late to report (5 minutes or less)
- ◆ Attempts to manipulate, refusing to take “no” for an answer
- ◆ Minor horseplay - stops with one caution
- ◆ Below average work, poor school notes that do not result in missing or being expelled from class

### Category 2

- ◆ Inappropriate verbal behavior, i.e. yelling, profanity, insults, persistent rudeness, teasing, disrespect, etc.
- ◆ Oppositional behavior, i.e. disobedience, defiance, not listening, refusing
- ◆ Horseplay, running, jumping, hitting walls, slamming doors
- ◆ Skipping or expelled from 1 class or activity, not doing details.
- ◆ Minor contraband, i.e. prohibited items which are not inherently dangerous
- ◆ Borrowing or lending personal items
- ◆ Late for activities, late to report (5-15 minutes)
- ◆ Inappropriate touching of self or others
- ◆ Throwing food or other non-dangerous items

### **Category 3**

- ◆ Inappropriate verbal behavior, i.e. abuse, aggression, threats, intimidation, citing others, openly defiant
- ◆ Physical threats or intimidation without physical contact
- ◆ Lying
- ◆ Skipping or expelled from more than 1 class or activity
- ◆ Using things that do not belong to you without permission
- ◆ Major contraband, i.e. possession of dangerous items or substances (may also result in legal charges)
- ◆ AWOL less than one hour

### **Category 4**

ANY CATEGORY 4 OFFENSE MAY RESULT IN FINAAL CHARGES, LEGAL CHARGES, AND/OR DISCHARGE

- ◆ Physical harm to self or others, i.e. physical aggression, self-destructive or self-mutilating behavior
- ◆ Destroying or defacing property
- ◆ Stealing
- ◆ Sexual activity involving physical contact or touching
- ◆ Possession of weapons, selling or distributing any type of contraband
- ◆ Being under the influence of any illicit substance
- ◆ AWOL more than one hour

## Suggested Consequences

The following are examples of suggested consequences based upon the severity of the infraction. This list is not all-inclusive, and the use of “natural consequences” (such as restitution, separation, written papers, verbal presentations, etc.) may be used in conjunction with the following point and privilege consequences or to establish contingences for earning privileges back early. **Consequences are not to be used punitively.** They are to be used to teach appropriate and adaptive behavior, and to discourage inappropriate and unacceptable behavior. Use of warnings, cautions, and teaching interactions should **precede** the use of consequences. At staff discretion, the resident may choose which privileges to lose from among those that have been earned.

### Category 1

- ◆ If the consequence is accepted and recorded and undesirable behavior is corrected immediately and without argument - loss of 1 point per occurrence and/or loss of 25 points from accumulated total
- ◆ If resident argues or refuses to accept consequences - loss of 3 points and/or loss of 100 points from accumulated total - plus the loss of one privilege (once)

### Category 2

- ◆ If the consequence is accepted and recorded and undesirable behavior is corrected immediately and without argument - loss of 2 points per occurrence and/or loss of 50 points from accumulated total
- ◆ If resident argues or refuses to accept consequences - loss of 5 points and/or loss of 150 points from accumulated total - plus the loss of one privilege for 24 hours

### Category 3

- ◆ If the consequence is accepted and recorded and undesirable behavior is corrected immediately and without argument - loss of 4 points and/or loss of 250 points from accumulated total - plus the loss of 1 privilege for 24 hours
- ◆ If resident argues or refuses to accept consequences - loss of 10 points and/or loss of 500 points from accumulated total - plus loss of 2 to 4 privileges which can be earned back at the rate of one privilege per 24 hours

**Category 4**

- ◆ If the consequence is accepted and recorded and undesirable behavior is corrected immediately and without argument - loss of 20 points and/or loss of 500 to 1000 points from accumulated total -plus loss of 2 to 4 privileges which can be earned back at the rate of one privilege per 24 hours
- ◆ If resident argues or refuses to accept consequences - immediate drop to Level 1 for 24 hours - Level 2 privileges can be earned back at the rate of 1 per day. After meeting criteria for Level 2, additional levels (up to the original level) may be earned back depending on points and staff recommendations and peer input in Peer Government

LOSS OF PRIVILEGES IN THE LEVEL SYSTEM IS NOT TO INFRINGE ON RESIDENT RIGHTS, WHICH MAY ONLY BE RESTRICTED BY SPECIFIC RECOMMENDATION OF THE TREATMENT TEAM.



# 5

## UNIT ADMINISTRATION

### **Intensive Residential Treatment**

The Youth Focus RTC provides intensive residential services to young people between the ages of 12 and 17. While residents admitted to the program are assessed as not being immediately dangerous to themselves or others at the time of admission, they often enter the treatment program with a long history of unhealthy behaviors, which can rapidly become hazardous in the absence of intensive supervision. Therefore, the Youth Focus RTC provides intensive, 24-hour monitoring and counseling of residents throughout their stay on the unit.

Staff members at the RTC should therefore be aware at all times of the potential for resident behavior to result in dangerous or unhealthy circumstances on the unit. Potential outcomes of resident behavior in the event of insufficient supervision include incidents of physical aggression or assault, property damage, theft, sexual acting out, and runaway or AWOL from the unit. The likelihood of such events occurring at the RTC is probably higher than at other levels of mental health care for youth (such as group home settings or outpatient counseling), as most of the young people in residential treatment have experienced numerous failed placements at lower levels of care. As less intense alternative placements or treatments are usually attempted prior to placing a youth at the RTC, a majority of the residents who are ultimately admitted to the RTC are at very high risk for engaging in overtly hazardous behavior during their stay.

Therefore, the RTC staffing and supervisory pattern, program guidelines, and level of treatment provided to the young people are designed to ensure a safe and successful course of treatment for each resident. In order to achieve this outcome, all staff members are expected to be fully familiar with the RTC treatment program and employee guidelines contained in this manual, as well as with the RTC policy manual and the Youth Focus employee handbook. Furthermore, all RTC employees are expected to maintain foremost in their minds the potential for hazardous or harmful behavior on the part of the residents, and to structure their time at the RTC and their interventions with the residents with safety of the young people and the community as an overriding priority.

## Working with Troubled Adolescents

The Youth Focus Residential Treatment Center is an intensive therapeutic facility designed to help adolescents with severe emotional and behavioral problems develop and practice more healthy and adaptive skills for succeeding in life's challenges. This is accomplished in the context of a structured program employing a point and level system that provides consistent incentives for positive, adaptive behavior as well as negative consequences for unhealthy acting out. With this program providing a safe and consistent environment in which the young people can follow their daily schedule, staff members are able to establish rapport with the residents and facilitate the process of learning about their unhealthy behaviors and practicing new styles of coping with conflict and stress.

An intensive residential treatment center typically works with young people who have been be chronically depressed, anxious, impulsive, and/or traumatized. The young people in the program generally suffer from problems that have become so severe that they can no longer be addressed safely or successfully on a community-based, outpatient basis. Many of the teenagers in the RTC program will have engaged in numerous examples of maladaptive behavior, including suicide attempts, abuse of drugs and alcohol, dangerous sexual promiscuity, physical assaults on family members, teachers, or other persons in authority, theft of property, or will have run away from their homes. The typical young person served at the treatment center is not a hard-core criminal or sociopath, but many emotional disorders can lead to patterns of behavior which may give this outward impression. Some of our residents may come from homes where family members are evidently healthy or "normal", while many of our young people have grown up in home situations rife with inconsistency, parental neglect, criminal activity and chaotic lifestyles. Many of the young people we work with have been abused physically and sexually, and some will have been abandoned by their families. A few of the residents at the treatment center may suffer from significant intellectual limitations, autism, or schizophrenia.

Youngsters who display impulse-control disturbances may engage in aggressive outbursts, running away, stealing, property destruction, impulsive substance abuse or sexual acting out. Young people suffering from a severe self-esteem disturbance often manifest suicidal behavior, self-injury or self-mutilation, preoccupation with rejection, severe negative self-image, disturbed body image, excessive self-blame, conflicts regarding success or achievement, poor interpersonal skills and an inability to effectively plan for the future. Individuals with anxiety disorders may have marked difficulty in public or social situations, generalized anxiety, post-traumatic symptoms, or specific fears or phobias. Some residents might suffer from physical symptoms which serve as a mask for their emotional difficulties; headaches, insomnia, stress-related skin conditions, and enuresis might all be caused by underlying psychological

problems. Many of these symptoms will be evident in the population of young people served by the Youth Focus Residential Treatment Center.

Due to the fact that most of the residents at the RTC have been unsuccessfully treated at other levels of care, and many have significant problems with trust and authority figures, the first task of a staff member working with a resident at the RTC is to develop a positive rapport or a connection with the young person. Avoiding judgmental responses to the residents and working hard to implement active listening skills will go far in helping establish a basic level of trust with a given resident. Supportive prompting and reminding about rules and expectations, as well as using verbal warnings and giving the resident opportunities to change their behavior prior to assigning consequences, will help the resident learn to view the specific staff member as being on their side and interested in their positive growth and development. Maintaining awareness that residents, due to past events in their own lives, might often misinterpret or misunderstand staff interventions will increase the likelihood that the staff member will recognize when this is happening with a resident. This provides an opportunity for the staff member to supportively explore and clarify the misinterpretation with the resident, and helps the staff member avoid responses to the resident which simply confirm negative views of adults learned throughout the resident's life.

Staff members should recall that open communication among the RTC team members will improve the treatment prospects for all of the young people in the program. To this end, staff members should regularly share their observations, insights and concerns about the individual residents with their supervisors, coworkers, and program therapists. Consulting with a more experienced colleague as to the best way to handle a given situation or behavior is recommended. At the same time, non-therapeutic "gossip" about the clients should be avoided. Residents who request that a staff member should keep secrets from other members of the team should be gently reminded that the RTC team approach is ultimately in their best interest, but the staff member should feel comfortable in taking on the role of advocate for a given client who appears to be reaching out to them for support or validation.

Due to the unhealthy family conditions many of our residents have experienced through much of their lives, a large number of the young people we work with suffer from problems in their ability to emotionally attach to other people. In some cases this might take the form of a broad inability to trust the motives of others, leading to a young person who is unable to open up and share with peers and staff about themselves, or a teenager who chronically assumes that others do not have their best interests in mind. In other cases, the residents we work with may trust or attach to others too rapidly or indiscriminately, resulting in a young person who may be vulnerable to future exploitation or mistreatment. In each of these cases, it is important to keep in mind the possibility that any given resident may have developed

unhealthy or self-endangering ways of attaching to others, and that you might be encountering these in your daily attempts to get to know, and develop rapport with, a given client. Keeping in mind the importance of serving as a role model for healthy strategies of relating is crucial here, and speaking with the resident's primary therapist at the RTC about your observations and how best to respond to a resident will prove immensely helpful in your work with the young person, and to their overall treatment while at the RTC.

One important factor in cultivating a therapeutic environment for the residents at the RTC is ensuring that the residential community is fundamentally caring and supportive of the young person's efforts to succeed and grow. While enforcement of the unit point and level system is critical in ensuring a consistent reward for positive, pro-social behavior in the program, it is important to remember that we want our residents to become more caring and cooperative individuals during their RTC stay, not simply more obedient ones. Individual residents will succeed at this if they feel fundamentally cared for by staff members, and believe that staff members are ultimately on their side in their quest for healing and recovery. Residents will only learn to cooperate with society by our cooperating with them, taking their interests and opinions seriously, and respecting their right to grow and develop as distinct individuals. Because our residents often come from homes which have modeled little in the way of caring and cooperation for them, it will take time before residents learn to trust the caring and consideration we show them, but ultimately they will internalize the positive attitudes we show them in our daily work together.

To this end, staff members working at the RTC should keep in mind that the example of your own behavior and attitude on the unit will serve as one of the most powerful teaching tools you can use with the residents. Staff members help the RTC residents best when they model kindness, consideration, and fairness in daily work with residents. Encouraging and praising compassionate and caring feelings and behavior in our residents will help them develop non-destructive and non-hurtful ways of expressing their own feelings, conflicts, and frustrations on the unit, and throughout their lifetime.

## **Staff Training and Responsibilities**

All staff members who work directly with RTC residents are required to complete training in a number of areas if they do not carry active certification in those areas when hired. Staff members must meet CPR and First Aid requirements in order to work, and should contact the Youth Focus Human Resources representative responsible for this training if they require training or retraining. NCI training is also

mandated for all staff members, who should contact the RTC Program Manager if they have not yet received training in this method of de-escalating crisis situations and safely restraining residents who require such intervention. The agency provides these training sessions at no charge to the staff member, and pays staff for time spent in the classes. Individuals who cannot attend Youth Focus training sessions will need to make arrangements to receive the training and certification elsewhere if they wish to continue working. Credentialing forms documenting training experience gained prior to employment at Youth Focus are available from supervisory staff and should be completed by newly hired staff during the initial orientation stage of their employment.

Additionally, all unit staff is expected to be fully familiar with the Employee Training Manual, and should sign the orientation form available at the staff station indicating that they have read and understand the policies and procedures outlined in the manual. Staff members are asked to give special attention to the information on Youth Focus policies regarding appropriate interactions and relationships between staff and residents. After confirming that staff have adequately reviewed and comprehended the training material and are in agreement with these expectations, the staff member's relevant supervisor should initial the form to indicate oversight of this orientation process.

In-Service Training sessions are scheduled throughout the year and follow regular staff meetings both at the RTC and at monthly agency-wide staff meetings. Staff members are required to attend at least six in-service training sessions (which may include mandatory training and credentialing discussed above) during the course of a given year. Attendance will be reflected in employee performance reviews. MHT's who have other employment during the day that precludes their attending in-service sessions should consult their supervisor in advance if they will be unable to attend.

Detailed minutes of staff meetings are distributed to each staff member with paychecks and can also be found posted in the staff lounge. All staff members are responsible for knowing the contents of these minutes, as important topics relating to the administration of the unit are often discussed or reviewed. The minutes enable the staff to keep abreast of important topics if they are unable to attend the biweekly meetings.

Staff members should be aware that a specific staff-to-resident ratio must be maintained at all times as mandated by our licensing. Therefore, advance notice is required when staff members cannot work their scheduled shift. MHT's must request vacation time before schedules are completed on Thursdays save in the cases of extreme emergency. MHT staff members are not permitted to find their own replacements and must contact the Residential Care Supervisor responsible for the

schedule in the case of an anticipated absence. Excessive switching of regular shifts by full-time MHT's is discouraged because it tends to disrupt consistency on the unit.

Each employee must take responsibility for completing and signing his or her time sheet by 9:00 on each Monday morning prior to payday. Noncompliance may result in an inaccurate paycheck or a two-week delay in receiving paychecks. Time sheets should reflect the number of hours actually worked (e.g., not "12 hours", if 8 hours at the 1½ overtime rate was authorized and worked). Note that all instances of overtime, and the reason it was authorized, should be documented on the back of the time sheet and initialed by a supervisor. The administrative office will add any overtime pay according to the explanation noted on the back. Time Sheets are available in the Time Sheets notebook in the secretary's office. If copies must be made, be sure to copy both sides of the time sheet. Full-time staff must document holidays which are taken (day off), or worked (eight hours overtime) and banked (for later use).

Each Youth Focus facility has its own rate of pay, and RTC staff who fill in at other locations are paid according to that facility's pay rate for the hours worked rather than the employee's hourly RTC rate. Overtime is based on the pay rate for the facility in which the overtime occurs after the completion of 40 work hours for each week.

Staff members should check the RTC Staff Log (located at the staff station) and mailboxes (located in the staff lounge) on every shift. All employees should have and use their own key cards to operate the magnetic security locks at the facility. Staff should immediately report lost or damaged key cards to the RCS and make arrangements for a replacement. Staff members who are assigned a long-distance telephone code are not permitted to use their code to make personal long distance phone calls. Staff should use a private calling card if it is necessary to make such personal calls at work. Staff members are not to take home any RTC entertainment items (videos, games, etc.), library books checked out by residents, or videos rented for the RTC. Any food or beverages brought onto the unit should be labeled with staff's name and the date, and the item should be placed in the staff lounge refrigerator.

Petty cash expenditures should be authorized by supervisory staff prior to any purchase. All receipts for approved expenditures must be retained and turned into the MHT-IV managing the petty cash. A balanced budget report has to be turned in to the administration office each month. Only the designated MHT-IV can disburse funds or write checks. Requests for petty cash expenses may be made during this individual's regular work shift.

## Resident Safety and Privacy

Regular monitoring of RTC residents is critical to ensure the safety of everyone on the unit. Staff members, at a minimum, should conduct hourly visual checks on all residents to ensure that the residents are breathing regularly and free from harm or injury. Monitoring sheets are to be completed each day and are to be kept at the RTC staff station.

RTC staff members are expected to conduct themselves in a manner that fosters for the residents an appropriate degree of privacy, safety, and freedom from intrusive or inappropriate contact or communication. Therefore, RTC staff members are required to adhere to the following procedures when on the unit and when supervising residents on off-unit outings:

- ◆ Staff members will take steps to ensure that all personal items carried onto the unit remain inaccessible to the residents. Staff members shall not carry onto the unit items which are potentially dangerous or which constitute contraband for the residents (cigarettes, lighters, razors, etc.).
- ◆ All shifts at the RTC shall be staffed with staff members of both genders whenever the resident census includes residents of both genders. Shifts at the RTC shall be staffed in such a way as to ensure a 3:1 ratio of residents to staff members.
- ◆ Off-unit outings in which residents of both genders participate shall be staffed with staff members of both genders.
- ◆ Staff members shall minimize their physical contact with all residents at all times, employ only approved TCI procedures when physically restraining youngsters, and have a second staff member witness all instances of physical contact with residents whenever possible. Staff members shall never engage in any sexual contact with residents.
- ◆ Staff members shall never allow themselves to be behind closed doors with residents of the opposite gender, nor shall they enter occupied opposite-gender resident bedrooms without a second staff member to witness on their behalf.
- ◆ Staff members shall announce their presence when they enter the opposite gender hall during periods of the day when residents might be dressing, changing clothes, or bathing.
- ◆ Staff members shall never fraternize with current or former residents.

As the above rules make clear, professionalism must be maintained by staff members at all times as they work with RTC residents. It is the responsibility of each individual staff member to enforce and maintain personal boundary limits with the residents. Staff members are encouraged to keep in mind the backgrounds of RTC residents and that even innocent actions or behavior can be misconstrued. While RTC staff should not behave in a cold or detached fashion, it is prudent to restrict unnecessary physical contact with residents, especially when it might be misinterpreted. A "no touch" policy should therefore be considered preferable to risking allegations of inappropriate behavior. Staff members should also be aware that some RTC residents have a history of making accusations about staff members at other facilities. Proper safety precautions should include following all RTC procedures, maintaining appropriate boundaries, and avoiding ambiguous situations open to misinterpretation.

Mandatory staffing of both genders is a safeguard that must be employed in all situations. Whenever possible, therapeutic holds should be initiated by staff of the same gender as the resident who is being restrained. A second staff member should monitor the hold and cosign the Incident Report. Male staff members should awaken the boys in the morning and female staff awakens the girls, and assistance with personal hygiene and other private issues should be similarly handled. Staff of the opposite gender should avoid entering halls when residents might be dressing, and should announce themselves when it is necessary to enter such a hall. MHT's are not permitted to be alone with a resident of the opposite sex at any time.

The RTC staff is charged with the responsibility of keeping residents safe and, in the event of witnessing a violation of these rules by staff or other individuals, taking proper action such as notifying a supervisor immediately. Credible allegations of inappropriate behavior by staff members will be reported to police and/or the relevant social service agency. It is mandatory that staff must report any behavior by other staff that appears suspicious or inappropriate for follow up by supervisory staff. It is important to be aware that even residents who are 16 years of age and older are considered to be victimized by inappropriate staff actions due to their role as recipients of treatment. Therefore, misconduct by staff members with a resident is considered a crime comparable to the abuse of nursing home residents and other vulnerable populations.

Similarly, fraternizing by off-duty staff with current or former residents is also not permitted. Staff members who must come to the unit but are not "on the clock" should promptly take care of work-related issues (such as completing a time sheet) but should not linger to visit with residents.

## Level System: Implementation

The RTC level system provides a framework for administering positive and negative consequences to behavior displayed by residents in treatment. Staff should ensure that the residents receive therapeutic responses to both desirable and undesirable behaviors. Staff members are encouraged to think of creative ways to acknowledge growth and focus on positive points whenever possible. However, staff should refrain from being extravagant in giving extra bonus points on the resident point sheets. A general guideline for granting bonus points is to equate one bonus point with one dollar in the "real world" as a means of judging the relative value of any given behavior prior to assigning points.

Staff should appropriately use the point system to accurately reflect the behavior of the residents. Points must be earned and, likewise, categories given, as warranted, for unacceptable behavior. Lesser categories with warnings may be used to defuse situations.

The system was designed so that privileges are lost and level drops result from receiving categories. In this way the residents have a chance to regain points and maintain their levels rather than immediately dropping a level for an infraction of the rules, which is permitted in extreme circumstances. Residents have copies of the Program Manual and should be prepared to take responsibility for their actions when the procedure is followed.

Residents should be made aware of their daily points to avoid surprises at Peer Government. Point Sheets should be done as frequently on weekends as they are through the week so residents will have equal opportunities to earn points and maintain their levels.

Residents on "sick bed" are permitted to earn a maximum of only one point in each area. If it is evident a resident is faking an illness, staff may give no points.

Telephone privileges are earned according to the Program Manual. Calls to professionals (social worker, pastor, etc.) don't count against the calls allowed for the various levels. Staff must log ALL telephone calls. MHT's must check the phone lists before allowing residents to make or receive telephone calls. Residents may abuse their phone privileges if staff permits this.

Residents who are not on the higher levels should not be allowed to participate in activities designated for the higher levels. It is difficult to motivate the residents to work toward a higher level if they already get those privileges. Residents who previously have had high levels receive privileges concurrent with their present level. Consistency must be maintained on all shifts throughout the week and on weekends.

Level 5 residents have the option of arranging their own bedtime. If a resident abuses the privilege and is not able to maintain their morning schedule, staff may intervene.

## **Therapeutic Interventions**

Therapeutic consequences should occur on the same shift on which an incident takes place. If staff feels that consequences should be extended through the next shift, detailed documentation must be made and the following shift workers briefed. Staff on the next shift may evaluate the situation and decide if the consequences should endure. Of paramount importance, however, is the fact that MHT's should support each other in consistently enforcing therapeutic interventions and minimizing efforts by residents to split staff members.

When peer isolation is necessary for its therapeutic value, the resident should not participate in school, group therapy, or group activities, which eliminates those opportunities to earn points. The resident should be separated from their roommate as much as possible. Peer isolation should be used quite sparingly, however, and in most cases the primary therapist for the resident involved should be consulted and give approval prior to implementation of this intervention.

Similarly, room restriction may be used as an effective tool at times, but should not be over-utilized. In general, both peer isolation and room restriction are appropriate as means of reducing the amount of secondary gain (i.e. attention and adulation from peers) which peers may garner from inappropriate behavior. Under other circumstances, appropriate therapeutic consequences may include having residents eat their meal or snack on the unit, loss of TV privilege for a limited time, confiscation of the resident's radio, extra chores or writing compositions, letters, or essays. These may all be used in lieu of point fines when category infractions are given, especially when the consequence has some meaningful relation to the offense. MHT's are encouraged to be creative in their interventions but are encouraged to consult with fellow staff and with supervisors prior to significantly deviating from the unit program as written.

Staff should use categories as designated in the Level System, with loss of level occurring as specified in Chapter 4 and immediate level drops employed only in extreme cases. Staff members should note that therapeutic passes are an important part of the residents' course of treatment and should not be considered a privilege. Therefore, authorization to cancel any therapeutic pass must be received from the resident's primary therapist or the on-call clinician the RCS on duty feel that the pass is not in the best interest of a resident at that time.

Communication among staff is essential to maintain consistency and fairness on the unit. Reports from residents are not always reliable and may represent an attempt to split staff. Therefore, staff members are encouraged to regularly discuss and process issues and concerns raised on the unit, and consult with supervisory staff whenever apparent inconsistencies or conflicts arise in interventions with the residents.

NCI is the official therapeutic means of employing holds or restraints with residents. Staff members who have received NCI training should be sure they know how to properly use the interventions, and if they have any questions they should promptly discuss these with the Program Manager. Whenever possible, male staff should restrain males and female staff should restrain females, and interventions should be witnessed and fully documented as such whenever possible. Ideally, staff who is the same sex as the resident should also assist in or monitor a restraint. The use of a basket hold is preferable for residents who have been sexually abused.

Residents should be closely monitored for a minimum of one hour after a physical restraint. As there is a risk of the body going into shock after a restraint, the resident should therefore be encouraged to move around. Even if the resident requests to be left alone or to rest, he or she should not be allowed to become sedentary or unattended. As fatalities have been reported as having followed restraints at other youth facilities, all RTC staff must be extremely cautious when therapeutic holds are employed.

Physical restraints are always reported on Variance Report forms, and an internal Youth Focus review is made periodically of these reports. Unit staff should familiarize themselves with the Variance Reports and what constitutes a variance (see below). Documentation of all therapeutic holds should be made on a Variance Report by the person who initiated the hold (what was done and why) and the form signed with comment by the RCS. This allows for tracking frequency and improvements.

## Variance Reports

Variance reports provide a means of documenting events which occur at the RTC which are out of the ordinary and may warrant further investigation or review. Variance report forms are located in the file cabinet behind the staff station, and should be completed by staff whenever any of the occurrences listed below take place in the course of a shift. The form should be completed by the staff member involved or witnessing the event, and should be cosigned by the Residential Care Supervisor on duty. (*see policy 2215*)

Events warranting completion of a variance report include:

- ◆ Use of quiet room for more than fifteen minutes

- ◆ Physical holding or restraint of resident
- ◆ Accidental injury to staff or resident
- ◆ Suicide gesture or attempt
- ◆ Property damage
- ◆ AWOL or runaway from unit
- ◆ Self-injurious behavior
- ◆ Report of sexual abuse
- ◆ Injury during a physical hold
- ◆ Assaultive behavior
- ◆ Medication administration error

## Documentation in the Charts

A State approved form is used for entering Progress Notes in the residents' charts. Only permanent black ink may be used in charts. Three notes per day - early morning, mid-afternoon, and early evening - must be written in the **Goal, Intervention, Outcome (GIO)** format. It is important to note that the "intervention" always details what the staff member did in intervening with the young person, and the "outcome" indicates the resultant behavior of the resident. The "goal" may be entered as a numeral referring to the numbered goals located in each resident's treatment plan, and the intervention should always be relevant to the goal selected for documentation. The notes should always address the most intensive intervention performed with the resident on the given shift, or relate to behaviors manifested by the resident which most closely relate to their treatment plan as documented in the chart. Guidelines for documenting are posted at the staff station and should be consulted when formulating notes. When residents are AWOL or on a therapeutic pass, simply note this in the chart at least once per shift. Document time of departure and return; if possible, use the GIO format. Additional documentation may be written on the Progress Notes forms and "N/A" written in the unused spaces in the section. Only approved abbreviations can be used in chart documentation. A list of approved abbreviations is in a folder at the staff station. A note indicating staff "co-facilitated" or "co-supervised," must be signed by both staff.

Errors made in the process of documentation should be marked with a single line through the incorrect portion of the note, and the error should be initialed and dated. Use of White-out or scribbling out notes is prohibited. If there is a reason not to complete a note (such as starting one in the wrong resident's chart, which should be guarded against), the writer should always note "error" and initial it.

Third shift staff must record each resident's presence or absence *as of 11:59 p.m.* Staff must confirm that the right resident is in his/her bed when rounds are made throughout the night and that documentation is made in the correct charts. They may use "observed" for residents who sleep throughout the shift; however, if there is any interaction (including awakening an enuretic resident to use the bathroom), that should be documented as an intervention.

Progress Notes should not be removed from the charts at any time. When third shift staff files notes in the resident charts, the therapists' Group Psychotherapy Notes and the Weekly Progress Notes by the consulting psychiatrist should be intermingled with the Progress Notes *according to the dates*.

## Discharges and AWOLs

Whenever a resident is discharged from the unit (or under conditions of extended leave, such as AWOL status), the staff on the shift this occurred should see to it that the room formerly occupied by the resident is thoroughly cleaned. If clothing and personal belongings are left at the RTC because of an unplanned departure (AWOL, hospitalization, or admission to detention), those items should be removed from the room and secured in one of the large plastic boxes in the storage room.

In cases where a resident has run away from the unit (AWOL off grounds), the RCS should immediately contact the Greensboro police to report the youth as a missing person. Complete information should be furnished as requested by the police to facilitate this report. The resident's legal guardian (identified on the face sheet in the resident's chart) should also be immediately notified of the runaway. If the AWOL occurs after hours, the RTC on-call clinician should be consulted. Finally, if the resident is a participant in the IRYS program (identified as such on the face sheet), that program should be notified through the internal voice mail system at the RTC (dial 436 without accessing an outside line, enter extension 3007, and leave a message indicating the resident's name and time of AWOL).

Upon a resident returning to the unit from AWOL, all relevant authorities listed above should be promptly contacted and notified. AWOL precautions (confiscation of a resident's street clothing in exchange for a hospital gown) may be instituted upon return from AWOL or in the event of serious AWOL threats or attempts by residents, but must always be approved by the primary therapist or by the on-call clinician.

Library books, school books, homework notebooks and other school material of departed residents should not be bagged with personal belongings; these should be given to the RTC teacher or placed in the classroom so that library books can be returned and other materials can be recycled.

## **Community Relations (Families and the Public)**

Staff members are expected to be conscious of community relations when talking with professionals and families. When dealing with emotional issues, it is important to be diplomatic, understanding and appropriate regardless of the other person's statements or tone of voice. At the same time, staff is not expected to subject themselves to extended verbal abuse. The wisest course of action under such circumstances is often to state that you cannot assist the person, and then either refer the individual to speak during normal business hours to a member of the RTC therapy staff, or get off the phone diplomatically and page the on-call person.

Similarly, staff who talk with visiting parents should strive to help the parents understand and feel comfortable with the treatment their son or daughter is receiving at the RTC. Questions about a resident's treatment should always be referred to the resident's primary therapist.

## **Grievance Procedures for Consumers**

When a resident or a member of the resident's family has a complaint or grievance with regard to their treatment or other related activities, the most effective means of resolution usually is for the individual to discuss the situation with the relevant primary therapist. Therefore, staff members are encouraged to refer the consumer to the primary therapist when they are unable to aid the individual in resolving the problem or complaint. Complaint forms are also available behind the staff station and at various locations throughout the unit (therapist's offices, day room, classroom, and dining hall) and should be provided whenever a consumer requests a form. Completed forms that are turned into staff members should be promptly forwarded to the RTC Director. (*see policy 2202*)

## **Medication and the Consulting Psychiatrist**

Residential Care Supervisors are responsible for administering prescribed medications to residents and properly securing them in the medication cabinet in the staff lounge. RCS's also bear responsibility for safeguarding the medicine cabinet key. MHT's may assist under the direction of the RCS, but, as a general practice,

do not administer the medications to residents themselves. If an RCS is not present on the unit, however, other staff who have passed the medication administration training may be designated to give the medication.

Medications for a given resident should be prepared, administered, and fully documented prior to moving on to the next resident. Residents are not allowed in the room where medications are kept under any circumstance. The staff member administering medication should place the medicine in a plastic pill cup and administer the medication to the resident at the water fountain located on the unit corridor. If the staff member needs to leave the medication room for any reason during the process of preparing the medications, the medications should be secured in the locked medicine cabinets prior to the staff member leaving the room.

Some residents have been noted as being quite skillful in hiding medication rather than swallowing them. Therefore, staff should be sure that pills are consumed at the time of administration. Documentation (staff initials) must be made in the Medication Administration log for each resident when each medication is given. New prescriptions or changes in dosage for existing medications should be logged with a new line in the administration log. When a medication or dosage is discontinued by the consulting psychiatrist, remaining dates in the medication log should be crossed out from the point of discontinuation forward. As with documentation in the resident charts, notation in the medication log should always be in black ink, with any recording error in the medication log treated as a chart error - make one line through it and initial. Third shift staff is responsible for keeping a periodic inventory of the medications and notifying first shift staff when refills are needed.

The consulting psychiatrist gives new prescriptions to the RTC nurse or, if unavailable, the RCS on duty, who sees that these are faxed to Gate City Pharmacy on the same shift. When the medications arrive, the RCS on that shift checks them in and makes adjustments in the residents' medication logs. The consulting psychiatrist writes a new prescription and Medication Order whenever he makes a change in an existing medication, such as altering the dosage or frequency. This is done to ensure that labels on the medication bottles are consistent with the most recent prescription. If the medication from the previous prescription has not been finished, those pills should be left in the bottle, designated "Re-label and Return" and given to the Program Manager for return to the pharmacy. Staff are encouraged to communicate with each other if they note any difference between the medication log instructions and prescription bottles.

The consulting psychiatrist notes on a Medication Order form when medicines are stopped. The discontinued medications should be labeled "Discard" and given to the Program Manager for proper disposal and to ensure that these are not dispensed.

Over-the-counter medications (including cough drops) should be clearly labeled with the resident's name and placed in his or her medication basket. If the parents or guardians provide the medicine, it should never be administered to any other resident. If over-the-counter medications are needed for or requested by other residents, petty cash may be used to purchase these at the discretion of the RCS. All medications must be kept in the medication cabinet in the staff lounge and dispensed in cups. Staff should not take medication cups for their personal use.

Residents who leave the center on therapeutic pass should take their bottles of medicine with them rather than traveling with individual dosages. The RCS on duty should ensure that all necessary medications are sent with the responsible adult when a resident leaves on pass. Guardians should sign the Therapeutic Pass form in the pass log at the staff station, relieving the RTC of responsibility while the resident is on pass, prior to leaving with the resident.

Any staff members who take residents to medical appointments should leave a detailed report in the staff log regarding the appointment, procedures, precautions, prescriptions, etc.

Therapists provide a weekly note on each resident for the consulting psychiatrist. Other staff may report their observations (particularly behavioral changes) to the therapists for inclusion in the notes.

The consulting psychiatrist's 800 telephone number should be used when he is needed for crisis issues after hours and on weekends, since his pager may not be on if he is not on call. For non-emergency needs, such as prescriptions or refills, he should be contacted during via his pager during business hours.

## **Orientation of New Residents**

At the time of admission, each new resident, his or her family, and representatives of other agents involved with the resident will be oriented to the unit philosophy by the Program Director, Resident Care Manager, or Recreation Therapist. This orientation shall address program rules and regulations, estimated length of stay, voluntary nature of the program, and Issues related to an unlocked unit. Upon arrival on the unit, the new resident shall be given a copy of the Program Manual and Admission Handbook. A member of the MHT staff shall be assigned to review program rules and resident rights in detail and to answer any questions. The process of explaining the Residents' Rights to the resident shall be documented in the resident's record. A peer monitor shall be assigned to help orient the new resident to the unit, help with introductions, answer questions, etc. (*see policy 2204*)

## Outings and Activities

Residents at the Youth Focus Residential Treatment Center have the opportunity to experience therapeutic off-unit outings under staff supervision. Eligibility for these outings will be determined by the resident's Level unless special consideration is prescribed by the individual therapist or the treatment team as a whole. The frequency of off-unit activities and outings will be subject to availability of adequate number of staff personnel necessary to ensure the safe and orderly completion of the outing. Therapeutic outings will be planned and coordinated by the Residential Care Supervisor on duty. Planning and/or execution of the outing may be made in conjunction with the Recreation Therapist or Unit Manager. The YFRTC Safety / Risk Management Committee shall provide a list of authorized outing locations to be used in planning off-unit activities. Only locations approved by this committee shall be used for such outings. The Safety/Risk Management Committee shall periodically review and amend the list of authorized locations based upon any identified safety concerns. The list of authorized outings shall be located at the RTC staff station.

As the success and safety of therapeutic outings requires the ability of all residents to maintain appropriate behavior in public, residents must qualify for participation in outings based upon their current Level in the unit behavioral system. During the course of any given week, efforts will be made to schedule and implement the following outings: one outing for residents Level 2 and higher, one outing for residents Level 3 and higher, and one outing for residents Level 4 and higher. (Exception: the individual therapist or the RCS on duty may qualify or disqualify an individual resident from participating in a given outing for a variety of possible reasons. This decision is always available at the discretion of the staff member, but should always be accompanied by specific feedback to the resident regarding the reason for the decision and specific suggestions as to how the resident might successfully qualify for the next scheduled outing.) No off-unit outings will be conducted at any time the unit is on Therapeutic Lock-Down status.

Residents should be on the appropriate level to participate in off-unit activities. The RCS on duty has the final authority in making decisions regarding residents participating in off-unit activities; however, the Level System should be followed in such decisions. If residents are permitted to participate in privileges without earning the level for those privileges, they lose incentive to achieve higher levels. It is particularly critical for the Program Manual to be followed on weekends. Staff may not take residents to their homes, to their other job sites or "cruising."

Locations for recreational activities are approved by the Safety/Risk Management Committee and listed in the recreation notebook at the staff station. Staff should be aware of any medication precautions relevant to residents being exposed for

prolonged periods to the sun and heat, and should contact the on-call clinician if concerns or questions arise. Drinking water should be available to residents when they are outside on hot days.

Interaction or shared activities between residents of the RTC and the Act Together program is prohibited because of licensing regulations.

Staff must be cognizant of potential problems which can be encountered when our residents are on recreational outings. Staff with greater familiarity with the residents or the program is encouraged to help new staff identify or anticipate hazards or problems, such as residents acquiring contraband (particularly cigarettes); manipulating, engaging in negative or flirtatious behaviors, etc. Staff should note that shopping malls are high risk areas that may be appropriate for only Level 3 and above residents. Residents must stay with staff on all outings. Check with the on-call clinician if there are any questions that the RCS cannot answer about activities or items that residents are not allowed to have on the unit.

Staff must closely monitor residents when on activities. Residents should not be allowed to separate from staff during outings. Residents must be checked for contraband upon their return from off-unit activities.

Residents are not allowed to view R-rated movies at theaters or on the unit. Staff must use mature judgment in the selection of movies and videos. Unrated videos should not be rented. Only designated staff (one person and a back-up) on the week day and weekend shifts are authorized to pick up and return videos. Videos should be returned promptly by the shift that rented them to avoid late charges. Staff has authority to confiscate tapes/CD's from residents if in the staff's judgment the words or music is not considered appropriate for the therapeutic unit, but a final determination in individual cases may be made by the resident's primary therapist.

All residents should participate in the exercise component of the recreation therapy program as a healthy, therapeutic component of their experience at the RTC. If these activities take place at another location, residents who cannot leave the unit should still be encouraged to exercise.

If all residents are permitted to leave the facility for an activity, all staff may accompany them after placing a sign on the front door to let visitors know the time staff will be "available" at a given time, without overtly stating that the unit is vacant. Voice mail should be activated and checked for messages upon return.

Departments of Social Service that hold custody of our residents should be notified if plans are made to take the residents out of Guilford County. If an activity is planned in advance, calls can be made during DSS working hours; otherwise, the respective on-call workers would need to be called for permission.

If the staff ratio allows, church services could be an optional activity for residents. However, caution must be taken because some legal guardians may not approve of choices staff may make. Permission should be obtained in advance from legal guardians via the resident's primary therapist. It is acceptable for legal guardians or other family or friends on the authorized visitors list to take residents to church at their own discretion. It is important that staff remain aware that one component of maintaining professional boundaries with residents includes not imposing their own religious belief system on the residents.

The staffing ratio on all off-unit outings will be three (3) residents to a minimum of one (1) staff. If male and female residents are on the activity, a male and female staff member will be assigned to accompany the residents, regardless of the number of residents participating. The staff left on the unit will be informed of destinations and estimated length of time the residents will be there. New admissions to the unit must be on the unit for a minimum of three days before being allowed to go on outside activities. Any resident receiving a category IV or two (2) category III infractions will not be allowed to go on outside activities that week. (*see policy 2206*)

## **Peer Government**

The purpose of Peer Government is to provide residents and staff a forum in which they may exercise their responsibility to contribute to the creation and maintenance of a fair, effective, pleasant, and harmonious therapeutic environment.

All residents Level 2 and above qualify to vote in Peer Government elections. Peer Government officers are elected by open vote of the eligible residents and available staff. Elections take place prior to the close of the weekly Peer Government meeting. If no resident is eligible for an office, a staff member will be designated by the treatment team to fill that office until one or more residents becomes eligible, whereupon a special election will be held. All residents on Level 3 or above may be nominated for the offices of president or vice president. Residents may refuse a nomination unless it is supported by a simple majority vote. Offices are filled by a simple majority vote. If no candidate receives a majority vote, a run-off election for the two receiving the highest number of votes will be held. After the president and vice president have been elected, residents on Level 2 or above may be nominated for the office of secretary. Residents may refuse a nomination unless it is supported by a simple majority vote. Officers are filled by a simple majority vote. If no candidate received a majority vote, a run-off election for the two receiving the highest number of vote will be held.

The Peer Government president conducts therapeutic community meetings (TCMs), presides over the weekly Peer Government meeting, and proposes special

agenda items to Program Director and Unit Manager prior to weekly Peer Government meeting and/or TCMs. The President presents approved agenda at the Peer Government meetings, sees that the agenda is followed, and presents motions and requests for level changes for a vote. The president is also responsible for appointing committees and assigning special tasks, and to see that decisions are implemented. The vice-president assists the president in the performance of his/her duties and serves as president in the absence of the president. The Government secretary records minutes and tabulates agenda of items to be discussed in meetings.

Items may be placed on the agenda by staff or by any resident with voting privileges. Residents may request items to be placed on the agenda by presenting a written proposal or issue to the president or other Peer Government officer who will then present it to the agenda committee. The agenda committee consists of the Peer Government officers, Program Director, and Unit Manager. Requests that an issue or motion be placed on the agenda for discussion or action at the next meeting may also be made during the "new business" level of the Peer Government meeting. The request will be considered by the agenda committee prior to the next meeting and the agenda committee will decide whether to include the item or not. If an item is not included, a member of the agenda committee will furnish an explanation to the person who proposed the item.

The Program Director or his designee (usually the Unit Manager) has veto power over all decisions of Peer Government. The reasons contributing to any such veto, however, will be explained to the community at that time. (*see policy 2207*)

## Quiet Room

The RTC Quiet Room provides residents with a quiet, non-stimulating environment to allow de-escalation in a therapeutic manner. Acceptable reasons for use of the Quiet Room include decreasing stimulation for the resident who is overwhelmed by unit stimulation, preventing interference with the therapeutic environment, and providing an opportunity for the resident to privately ventilate emotions.

Use of the Quiet Room should be voluntary in nature, initiated with or without staff encouragement, and should generally be time-limited (usually 15 minutes or less). The procedure must be documented along with the results. Use of the Quiet Room is not to be confused with "seclusion" or "isolation time-out," as it can be terminated by the resident when calm enough to re-enter the community and is conducted in an unlocked area with no barring of the resident's exit. Seclusion and isolation time-out are procedures which are not to be used at the RTC.

Residents should be observed closely during their stay in the Quiet Room, and support offered if deemed therapeutic by staff. The resident may terminate use of the Quiet Room voluntarily, but may be encouraged by staff to continue if necessary. Documentation is necessary to explain the need for the procedure and the results during and following the Time Out. The use of the Quiet Room is strictly for the resident to gain better emotional control and is *never* to be used as a punitive measure. (see policy 2213)

## Resident Hygiene

Residents at the Youth Focus RTC are expected to be responsible, in so far as they are able, to adhere to standards of personal cleanliness and hygiene. The RTC should provide an environment facilitating maintenance of a clean and healthy environment for residents and to aid residents in learning personal hygiene and self care skills and responsibilities. Residents are responsible for laundering their own clothes utilizing either their own detergent or detergent supplied by the RTC for that purpose. Residents should have at least one clean change of clothes, including underwear and outerwear, at all times. They should keep their clean clothes neatly hung and/or folded, and keep dirty clothing in a hamper or wash basket. Showering or bathing at least once daily using their own soap, shampoo and/or toilet articles, is required of all residents. They should also brush their teeth at least two times daily using their own toothbrush and toothpaste. Residents are responsible for stripping of beds and changing of linen. An opportunity for residents to clean their bed linens will be provided two times per week. (see policy 2208)

## Room Searches

Room searches may be conducted upon the direction of the Residential Care Supervisor (RCS) to maintain the safety of the residents and the integrity of the milieu. Authorization for a room search should be obtained from the Residential Care Supervisor (RCS) when a staff member deems it necessary to conduct a search of a resident's room. The RCS will inform the resident(s) involved of the need for the room search. The RCS will inform the resident of his/her right to be present while the room and belongings are searched. There should be two staff members present while the search is conducted, and the On-Call Clinical Supervisor should be notified of any contraband found. Such contraband will be identified and the disposition noted on the chart. A variance report will be completed and will include documentation of the RCS's authorization, time of authorization, description and disposition of any contraband found. The variance report should be placed in the Program Director's mailbox. (see policy 2211)

## Safety

The Emergency Preparedness Book (red notebook) is the staff work station. The book, along with the cellular telephone, should be taken outside whenever there is a disaster or fire (or drill) so that calls can be placed to the emergency contacts listed in the book.

Staff must be alert and observant for the safety of the residents and staff. Residents can quickly pick up items, such as cigarette lighters, that unintentionally may be left by staff within the reach of residents. When items are given back to residents who have been on AWOL precautions, the storage box should not be given to the resident in case contraband items had been placed in it prior to the AWOL precautions.

Safety issues to remember:

- ◆ When residents return from being off the unit (group outings/individual pass), make a thorough check to eliminate the possibility of contraband being brought on the unit.
- ◆ Residents in hospital gowns cannot go beyond the double doors and definitely not outside the building except in an emergency.
- ◆ NO glass is allowed on the unit, including picture frames, juice bottles, etc.
- ◆ Do not give a key card to a resident.
- ◆ Potentially dangerous items (White Out, glue, etc.) must be kept behind the staff station and out of possible reach of residents.

Razor blades are contraband. Staff of the same gender must be the residents when they shave and return the razors to the proper storage place.

Because of the possible risk of toxic shock syndrome, tampons are not provided for female residents. Therapists are encouraged to get permission from the girls' parents/guardians before tampons are permitted.

Staff who smoke should not do so within sight of residents. They must be cautious about leaving burning cigarettes in the outside ash trays. Cigarettes that are not completely smoked should be broken so that a resident can not retrieve and relight it.

## PROVIDE STATEMENT ON CIRCUMSTANCES REQUIRING VARIANCE REPORTS

The facts, not opinions or impressions, should be stated on Variance Reports. Initials instead of the resident's name may be used on a Variance Report.

### Suicide Precautions

Any suicidal ideation or threat made by a resident at the Residential Treatment Center shall be taken seriously and appropriate strategies initiated. Suicide precautions ensure that the resident is given emotional support, close observation and protection from self-destructive behavior in the least restrictive manner. Suicide precautions are initiated by the primary therapist (or residential care supervisor after consultation with the on-call clinician) when a resident demonstrates verbal or non-verbal behavior, or covert or overt actions, which are considered to represent a serious threat to self or otherwise are deemed to represent a suicide risk. The relevant clinician will determine, in consultation with the program director and/or medical director as needed, the nature of the intervention warranted based upon the resident's clinical presentation and history. This determination will include whether the resident requires continuous observation or 15-minute checks, and whether hospitalization or petition for involuntary commitment is warranted. Suicide precautions may be discontinued only by the primary therapist or residential care supervisor after consultation with the on-call clinician.

#### Suicide Precautions Procedure:

1. Document in the resident's RTC medical record (GIO Notes section) the behavior necessitating the precaution. Specify, based upon consultation with the primary therapist or on-call therapist, whether the intervention to be implemented should involve **continuous observation** or **15-minute checks**.
2. The type of intervention employed shall be determined based upon the specific nature of the behavior leading to the need for suicide precautions, as well as the resident's relevant clinical history. In general, suicide precautions with **continuous observation** will be warranted in situations where the resident's expressed suicidal intent is severe and persistent, where the resident is unwilling to contract for safety with clinical staff, when a

specific plan for self-injury can not be precluded through management of the milieu, or when a petition for involuntary commitment is being pursued for the resident due to their level of dangerousness. Suicide precautions with **15-minute checks** would typically be more appropriate when a resident has contracted for safety, has non-specific suicidal ideation, when management of the milieu environment can significantly reduce risk of self-harm, or when criteria for involuntary commitment are not met. The determination of the appropriate level of suicide precautions should always be made based upon the resident's specific clinical presentation and history, and in consultation with the on-call clinician, program director, and/or medical director as appropriate.

3. Staff should explain suicide precautions procedure to the resident. The intervention should be documented on the relevant tracking form (see attached). The continuous observation intervention places same-gender staff monitors in the room with the resident and provides constant 1:1 observation, including close supervision during toileting, personal care, etc.
4. Staff members should conduct a complete personal and a room safety check for sharps and other potentially dangerous items upon initiation of suicide precautions.
5. Remove long, thick shoe strings, belts and other potentially dangerous personal items.
6. Conduct a room safety check once each shift and remove any potentially dangerous items.
7. The resident is not allowed off the Residential Treatment Center unit for any reason unless specifically authorized by the primary therapist or on-call clinician and then only with close 1:1 monitoring and supervision.
8. Record the resident's behavior every 15 minutes and at the end of each shift on the special precaution sheet.
9. Encourage physical and mental activity. Inactivity may increase the resident's suicidal ideation by allowing brooding.
10. Anticipate the resident's behavior by being aware of changes in mood.

11. Staff should remain aware of especially dangerous periods: shift change, early morning hours, mealtimes, night shifts, weekends, holidays, while using bathroom, after family visits, and when unit distractions occur.
12. An eight hour summary progress note should include:
  - a. Assessment of the resident's mood and behavior.
  - b. Verbal and non-verbal behavior indicative of status of suicide potential (ex: Resident's statements regarding depression, hopelessness, etc.)
  - c. Resident's response to explanation of suicide precautions, degree of understanding, and ongoing reaction to suicide precautions.
  - d. Any threats, gestures or sudden mood changes.
  - e. Disposition and description of belts, shoe laces or other personal items removed from the resident's possession.
13. When a resident has made an actual suicidal gesture/attempt, the severity shall be evaluated and care initiated by the primary therapist or residential care supervisor after consultation with the on-call clinician using the Residential Treatment Center process. Consultation with the RTC Program Director, Program Manager, or their designee shall be initiated to determine the need for inpatient hospitalization and appropriate follow-up action shall be taken based upon that consultation.

All residents admitted to the Residential Treatment Center program will be screened for suicide risk upon admission:

1. Residents referred to the RTC program will be screened by the RTC clinical team for evidence of ongoing suicide risk. Residents who present with a high risk of serious self-injury or suicidal acting out, or a recent history of such, will be carefully screened by the team and referred to a more secure or restrictive program as warranted by the clinical information available prior to acceptance into the program.
2. At the time of admission, the RTC clinician processing the admission will screen the resident for current suicidal ideation and risk of self-harm. This will be accomplished by interviewing the resident, the legal guardian, and any other adult informant(s) present at the admission, regarding these factors.
3. Residents assessed by the admitting clinician as being at imminent risk of suicidal acting out at the time of admission will be considered for involuntary

commitment to a more secure hospital setting. This determination may be made in consultation with the RTC program director and/or RTC medical director as appropriate. In cases where the criteria for hospitalization are not met, but significant risk of self-harm is noted, the admitting clinician may authorize the use of suicide precautions upon admission to the RTC program (see above).

## Infection Control

It is very important that we provide a safe and clean environment for our clients and staff in all Youth Focus facilities. As a result we have developed some fairly simple rules for you to follow. Most of these rules are just common sense and probably close to what your mother taught you at home!

### **TWO KEY RULES:**

1. Keep the facility clean.
2. Wash your hands a lot.

So what do we mean by a clean facility?

First and foremost keep the kitchen and bathrooms extra clean. Disinfect commodes, sinks, bathtubs, showers and floors at least weekly. Keep the garbage can in the kitchen covered at all times. Clean up spills right after they occur. Most spills can be cleaned with plain water or warm soapy water. For more serious spills of bodily fluids - more to come later. Client rooms should be cleaned thoroughly after a client is discharged - all linens cleaned, mattress cleaned, etc. Appliances in the laundry should be cleaned at least once a week. Wipe the dining room table/kitchen table after each use and counter-tops as needed.

Why is washing your hands so important?

This is the single most important infection control procedure you can use. You should wash your hands when you come on duty, before and after physical contact with clients, after contact with any infectious material, before serving food, before and after administering medication, after bathroom use, before eating and after coughing or sneezing.

Good hand washing requires lots of warm water, soap, and one to three minutes to complete. Also, encourage clients to wash their hands too, but as always avoid power struggles!

**Sick Client or Staff:** If a client to be admitted to the facility is sick or has a highly contagious disease we may want to delay their admission until they are feeling better or no longer contagious. Some sick clients may need to be isolated from other clients – for both of these issues consult with your supervisor who will get a medical opinion. If you or another staff member is sick and/or has a contagious disease it is probably better that you don't come to work until you are better.

**Bodily Fluid Spills:** Any body fluid that you have to clean up or dispose should be treated as if it has seriously bad germs, viruses, etc. in it. You just never know. So any body fluid – blood, urine, feces, etc. should be treated as if they are contaminated and you should use what we refer to as Universal Precautions. That really just means you assume the spill is dangerous and act accordingly:

- i. Wear latex gloves when cleaning up spills.
- ii. All bandages, paper tissues and other disposable items that are contaminated should be discarded carefully – placed in an impervious (plastic) bag and disposed of in the trash.
- iii. Any spill should be cleaned with a bleach and water solution or other approved cleanser (4 oz. of Clorox to one gallon of bleach).

**Food Preparation and Storage:** Improper food storage and cooking can make people sick as well. Again, keep the kitchen extra clean. Do not leave cooked food out too long – remember the adage: “Two hours too long”. Food left out longer than that can spoil. Be careful when handling raw meat and eggs, especially poultry. Wash all surfaces after cutting chicken and other meats with a weak bleach solution.

If you want more information on infection control please refer to our Policies and Procedures Manual.

## Community Cleanliness

Staff and residents must work together to maintain the cleanliness standard for the unit, particularly in the common areas. The residents should be assigned regular chores on the unit, as is typical of adolescents in other living circumstances. Staff

members should supervise and check all residents' rooms daily. The residents must be very closely supervised if they clean the Plexiglas windows because they scratch easily. Cleaning supplies are available in the laundry room. Staff should ensure that cleaning materials and trash bags are not wasted or "misplaced." It should not be necessary for staff to retrieve any items from the storage shed, as these items are distributed regularly by maintenance personnel.

If there are spots on carpets or other areas that need special attention, these should be pointed out to the janitor when he is cleaning. Shower curtains should be laundered by third shift one night each month. These may be washed on the gentle cycle with a reasonable amount of Tilex or similar product. Personal belongings taken or confiscated from residents must be bagged, labeled and put in the former proper storage room, not at staff workstation. Residents are not allowed in the storage room or laundry room without staff supervision.

Staff should encourage residents to prepare at night for the next day, such as doing some of the housekeeping chores, taking showers, and having their clothing ready. Staff members should be wary of residents who may try to avoid completing required bathing and hygiene. MHT's should also be certain that residents are washing their clothing on a regular basis. If a resident is unable to take care of his clothes (keeping clean and dirty clothing separate, etc.), staff assistance must occur. Enuretic residents should be awakened during the night to visit the bathroom, and should participate in stripping and cleaning of bed linens should they wet their bed. Staff should ensure that the bed linens that are changed are laundered during the shift that this occurs.

Trash should be taken to the outdoor dumpsters rather than placing trash bags in the janitor's closet. Green trash bags are placed in waste baskets at various locations and are only used for recyclable items. Residents are responsible for putting toilet tissue in the holders in their bathrooms, but again staff members should oversee these responsibilities and ensure that residents complete them. A key to the locking holders is on the RCS key ring.

Staff members are responsible for ensuring that the RTC van is kept clean. Residents should remove their trash from the van after outings. The exterior of the van should be kept clean also. Residents may earn extra points by washing the van with MHT supervision.

Food items should be labeled with a name and date when placed in the staff lounge refrigerator, and all food should be removed before the foods spoils. Staff should properly dispose of the remains of food they bring in and wash and put away dishes, cups, or utensils before the end of their shift. Food should never be left open on counters behind the staff desk or in the staff lounge at the end of any given shift.

## Facilities and Community Property

Windows in the resident bedrooms should not be opened, as this adversely affects the operation of the heat or air conditioning. Staff should check the windows regularly since it is not easy to tell from the inside of the building that a window may be open. Thermostat settings may not be changed by staff. The RTC Program Director or Youth Focus Assistant Director should be notified if the temperature on the unit becomes too uncomfortable.

Staff should immediately address any problems with toilets continuing to run, as this can cause a tremendously increased water bill. The shut off valves should be used until the problem can be rectified.

It is not permissible to use transparent tape (scotch) on the painted walls on the unit, especially in the Day Room. Posters may be placed on doors with transparent tape.

Residents are not to take wash cloths, towels and personal care items with them when they go on pass. Room and bed identification should be put on the bath linens and a weekly inventory conducted. If residents cannot produce their towels and linens, funds for replacements these can be deleted from their recreation allowances with the approval of the Recreation Therapist. Hygiene supplies can be requested through the Food Service Manager and kept at the staff station.

Residential Care Supervisors are responsible for the RTC key ring and for accessing locations where supplies and equipment are kept. The RCS on duty should keep the key ring on their person at all times, and should refrain from allowing other staff or residents to borrow the key ring without supervision. As items - including food, dishes, snacks, and fruit - have disappeared from the kitchen and storage areas in the past, general staff are not to have access to these supplies. Staff members are expected to show adult responsibility at all times, and are not to take items that do not belong to them or allow residents to do the same. Staff should report inappropriate actions of coworkers if they observe items that belong to the RTC being removed. Similarly, residents are not allowed to share or borrow clothing or other personal items because this usually results in conflicts, misunderstandings, and accusations.

## Kitchen and Food Services

Only dietary staff, the RTC administrative personnel, the consulting dietitian, and other personnel as needed to conduct infection control audits are allowed to enter the kitchen on a regular basis. All other staff members are not permitted into the kitchen except when dietary staff is unavailable to provide meals. In the evenings,

staff members are not allowed in the kitchen after the evening meal is served. Evening snacks will be placed in the dining room before dietary staff leaves for the day. (see policy 2402)

Diet orders are located in the admission notebook and completed as part of the admission procedure for each new resident. These forms should be turned in to food service staff immediately or taped to the kitchen window if no one is in the kitchen. A new form should be completed whenever there is need for a change in a resident's diet.

Extra portions of food generally are given only when the psychiatrist has approved a high calorie diet. Kitchen staff is responsible for the determining how to respond to resident requests for more food. The Food Service Manager makes a dedicated effort to accommodate food preferences of the residents but cannot cater to likes and dislikes. Consideration will be given to residents who are allergic to specific foods but if they don't like a particular menu item they should eat more of the other items offered.

Fruit is often provided for the night snack because residents do not eat the fruit on their trays at mealtime and there is less mess than with other snacks. Residents can improve on those two factors if they would like to have other things for the night snack. Only one snack per day is required by state standards. Unit staff must be sure the dining room is clean following the night snack since kitchen staff is not on duty at that time.

It is essential that staff, particularly weekend staff, take responsibility to return the residents from activities in time to have their meals on schedule. With one to two hours advance notice, the kitchen staff can prepare a meal that can be taken on a recreational outing so that the residents will not have to return to the RTC for the meal.

MHT's should let the kitchen staff know when residents are on passes. Residents who miss mealtimes here while on passes should be provided meals before returning to the RTC.

Residents cannot give food on their trays to other residents or to staff. Even though a resident is not going to eat part of their meal or snack, they cannot give it to someone else. The menus are planned for balanced nutrition and adjusted according to the needs of individual residents, therefore, sharing food is not permitted. Staff may not eat food or fruit given food or fruit served to a resident.

Petty cash cannot be used to purchase meals (including fast food or snacks) for the residents. If an emergency makes it impossible for kitchen staff to be here to prepare a meal, residential care staff will be notified of alternatives. If inclement weather is

anticipated, the refrigerators and freezers will be left unlocked so that unit staff may obtain food for meals and snacks if kitchen staff cannot get to work because of dangerous road conditions.

Our plastic utensils are semi-permanent and should not be thrown away after meals.

The kitchen is off limits to all staff except management unless there is an emergency which necessitates the RCS going into the kitchen. Afternoon snacks are given out by kitchen staff and evening snacks are left out, therefore, staff should not need to go into the kitchen.

The ice chest is provided for staff use. For sanitation reasons, staff must get ice from the chest if it is needed for the residents. Water fountains are available for the residents.

Staff may purchase a \$3.00 meal ticket from the secretary to eat meals in the dining room. Kitchen staff should be given advance notice and may decline if there is not sufficient food available. The menu will be the same as for the residents. It is posted in the secretary's office and on the kitchen window.

A printer behind the staff station records the 15-minute resident checks throughout the night. To activate the printer, third shift male staff should swipe their key card at the end of the boys' hall with their security cards, and female staff will insert and turn their emergency exit key at the end of the girls' hall after each inspection. Staff should be sure the printer is "on line" (green light) and that the cable in the back of the printer is firmly seated. Proper operation of the printer should be audible when the locks are activated. If the printer is not working, the connection in back should be checked because it sometimes goes "off line" when bumped or moved. Staff is asked to be careful when walking near the printer to avoid disconnection.

## Alternatives to Restrictive Interventions

**How to avoid Physical Restraints** – Restrictive interventions such as a physical restraint should be avoided whenever possible. Clients and staff can easily become injured during a restraint. The information outlined below will give you many good ideas on understanding how a crisis develops that could lead to a restraint and ways to help a young person de-escalate from a potentially volatile situation.

### I. The Stress Model

#### Goals of Crisis Intervention

For young people in residential care being "in crisis" means having exhausted or never having learned effective, constructive, and rational ways of coping with or responding to stress, upset, or pain. Our job in intervening in the crisis, then, is twofold (a) to help the young person through the crisis safely and supportively; and (b) to teach the young person better, more constructive, effective ways to deal with stress or painful feelings.

#### Types of Crisis

To better anticipate crisis situations, it is helpful to understand the two most common types of crisis young people in care experience.

#### Situational Crisis

Events, everyday ones as well as major ones, can trigger crisis in young people. A new placement, a cancelled home visit, or a homework assignment can be stressful to the young people in our care and can cause crisis. We can often anticipate these situational events and prevent or intervene early in order to prevent crisis.

### **Maturational Crisis**

Another type of crisis young people experience occurs when they move from one developmental stage to another. Normal developmental progress places great stress on young people as they mature and grow. Untroubled young people find relationship-building, academic expectations, and compliance with rules stressful. Imagine how difficult these issues are for the young people in our care. Maturational crises are opportunities for us to help young people learn and grow.

### **Crisis as an Opportunity for Growth**

Crisis, in everyday usage, is most often associated with something negative as in a disaster of something that poses a threat, such as a nuclear crisis, an energy crisis, or the Mideast crisis. According to many psychologists, however, crisis is necessary and vital to the development of personality.

The majority of crises that young people in care experience are a result of the young person running out of coping skills and being emotionally overwhelmed. This is called reactive aggression. Occasionally, young people act out aggressively in a planful way. They are not overwhelmed by emotion, but are using aggression to achieve a goal. This type of aggression, proactive aggression, is associated with bullying. It is important to understand the difference between these types of aggression in a crisis situation.

### **Phases of a Typical Crisis**

The stress Model of Crisis offers a way to conceptualize the stages of crisis a young person goes through. It aids in highlighting the importance of direct care staff in helping the young person through the crisis in a way that will help to make it a learning experience for the young person. The first step in identifying when the young person is in a situation that is heading for crisis, is to know how the young person, staff and milieu operate “normally.” This is called the baseline or pre-crisis state.

### **Baseline or Pre-Crisis State**

Young people rarely erupt into a full crisis state without some triggering interaction with others or the environment. Sometimes young people are already agitated in the pre-crisis state due to factors beyond their control. The main factors to be considered are: the staff, the young people, the organizational culture, the policies and procedures, the program, the physical environment, and the interaction of these variables. By understanding young people’s normal functioning, and identifying their typical problem-solving behaviors, as well as their typical responses to frustration, we can better prepare ourselves to intervene early.

### **Triggering Phase**

The triggering phase is usually signaled by the first abnormal behavior or change in behavior. An event or events – situational or maturational – upsets a young person and increases the level of stress. The triggering phase may be linked to something very obvious and observable, or it may seem spontaneous and without warning. The specific behaviors will vary from young person to young person.

Many times a crisis can be prevented by establishing a routine that meets a young person's basic needs. Providing a safe and predictable environment goes a long way in helping a young person learn to cope with daily frustrations and upsets. Building relationships that support and encourage the young person to deal with problems and disappointments as they occur can prevent triggering events from escalating into crises. Self-awareness, plus an awareness of the young people and the environment, can help prevent situations from becoming crises. Gentle reminders, encouragement, and support are often enough to help young people regain control of their frustrations and anxieties. The program discusses these aspects of prevention and early interventions. Once the young person returns to baseline, we can process what happened and problem-solve.

### **Escalation Phase**

During the escalation phase, the young person becomes more and more upset or agitated and begins to be disruptive. At this point there are some obvious signs of increased anxiety. As the intensity of these behaviors increases, the likelihood of the young person responding to intervention decreases. During this phase the young person is showing signs of loss of control, such as talking louder or withdrawing. The young person may be threatening or behaving in ways that are recognizable signs of escalation.

During the escalation phase other young people in the group may be easily influenced. "Group contagion" is always a concern in group care. One young person can set a whole group off. The environment may be stimulating the young person. There are ways to reduce the stimulation and help the young person regain composure. At this state we must take purposeful action.

There are a variety of ways we can de-escalate a crisis in this phase. Self-awareness, in particular, awareness of how we interact with young people, is important for improving the skills needed to de-escalate crisis situations. Again, once young people are back to baseline, we can help them develop new coping skills.

### **Outburst Phase**

We know the young person is in crisis when that person acts in a manner that may be dangerous to other young people, to staff, and to the environment. Up to this phase, intervention has appealed to the young person's ability to respond rationally. Intervention now must provide for the safety and protection of the young person, the other young people, and staff. Young people may move quickly from one phase to another. It is, therefore, extremely important to recognize the triggering and escalation phases for each young person, and to intervene as early as possible in order to avoid using high risk interventions.

### **Recovery Phase**

Our goal should always be to intervene in a crisis in a way that is beneficial to the young person. The recovery phase is our opportunity to help the young person learn and grow from the experience. After the outburst the young person begins to calm down and relax. We must remain observant and supportive since some young people get depressed at this point. There are three possible outcomes in all crisis situations: (a) the lower outcome, (b) no change/no growth, and (c) the higher outcome.

1. Lower Outcome: The young person is damaged by the crisis or by the way in which it is handled. Perhaps there was no intervention and the young person was injured or injured someone else. Perhaps the adult who intervened lost control and hurt the young person. As a result the young person no longer trusts adult caretakers. Our role in this outcome is that of the "abuser". The young person has a decreased ability to handle stressful situations and may have regressed in treatment.
2. No Change/No Growth: The crisis is handled and the intervention takes place. Unfortunately, the young person does not learn from the situation. Therefore, the next time the trigger event(s) occurs the young person responds in the same manner, once again using ineffective coping skills. Intervention is handled in the same way and we end up "putting out fires," waiting for the next crisis. Our role in this outcome is that of "fire fighter." The young person continues to run and return or, perhaps, to fight and be restrained. There is no increase in the young person's ability to deal with stressful situations.
3. Higher Outcome: An intervention occurs in a therapeutic manner. The young person is helped to understand the dynamics of the crisis and how to prevent or handle it more appropriately. By processing the situation and planning for the next time, the young person gains some insight and/or commits to trying new behaviors. Our role in this outcome is that of "educator" or "teacher of life skills." The young person learns from this experience and has an increased ability to handle stressful situations and painful feelings.

## **II. Assessing the Situation**

### **The Importance of Being Aware of Feelings**

What we are feeling in a given situation has a direct influence on our behavior. Our behavior in dealing with young people is the result of our feelings of anger, fear, empathy, disappointment, frustration, calmness, etc. An awareness of our feelings in a crisis or potential crisis situation can help guide the situation to a successful resolution.

There are a variety of skills to use when intervening with an upset young person. These skills are neither intuitive nor natural. They do not necessarily evolve from experience. They require training and supervised practice to acquire and to achieve a level of competence necessary to employ in actual crises. We must also be aware of the feelings a situation evokes in order to help the young person on the verge of crisis.

### **Four Questions**

Four questions we can ask at the outset of a potential crisis to identify the most appropriate intervention strategy are:

1. What am I feeling now?
2. What does this young person feel, need, or want?
3. How is the environment affecting the young person?
4. How can I best respond?

### **What Am I Feeling Now?**

We communicate our emotions to a young person, even if we are silent or speak in a very controlled and calm manner. The cliché that one “cannot not communicate” is certainly true in dealing with crisis situations. Young people are astute observers of nonverbal behavior and often have learned to anticipate angry outbursts. They may be more attuned to our feelings than we are! Being aware of our feelings is the first step in controlling our behavior and what we communicate to the young person. It is also important not to let our emotions dictate our response in a stressful situation. When taking action in a crisis, we need to make rational decisions based on professional judgment.

### **What Does This Young Person Feel, Need, or Want?**

When dealing with an emotionally charged situation, this question leads to a discovery of what the young person’s goals are, or of what the young person is seeking to achieve by the behavior. It can also lead to greater empathy and understanding of the young person because it reveals how the person’s behavior represents an attempt – however dysfunctional – to meet a need. This may, for example, be: (a) a need to feel safe, (b) the desire to be treated fairly, (c) a need for attention, or (d) the desire to feel important or to be accepted.

Asking ourselves, or even the young people themselves, what they need or want helps avoid misinterpreting their intentions or concluding that “she’s just bad,” or “he’s just out to give me a hard time.”

### **How Is The Environment Affecting the Young Person?**

It is important to manage the environment. Many times potential crisis can be prevented or diverted by modifying those conditions in the environment that might be contributing to the stressful situation. If other young people are present, they may be watching and become agitated by the interaction or they may be providing the stimulus that is raising the vulnerable young person’s anxiety. It is, therefore, important to ask ourselves, are any triggers in the environment setting the conditions for aggression.

### **How Can I Best Respond?**

It is our response that will de-escalate and defuse a volatile young person in most cases. We should constantly keep in mind the need to respond to the young person in crisis in a timely, helpful, therapeutic manner. In order to be in control of a crisis, we must first be in control of ourselves. In dealing with a potentially volatile and destructive young person the dilemma is to:

1. Manage the environment to neutralize potential triggers.
2. Engage the young person and defuse the acting-out behavior or contain the dangerous behavior.
3. Exercise self-control over the feelings the situation evokes.

Volatile situations are dynamic and constantly changing. We continually make judgments in attempts to de-escalate the situation. We must assess the situation, decide on a response, respond, and then monitor and evaluate the impact of our behavior on the young person and the situation.

### **III. The Importance of Self-Awareness: What Am I Feeling Now?**

#### **Awareness is the Key to Crisis Control**

When we deal with young people who are upset and in crisis it is important to ask, could things have been done differently? Sometimes, things could have been handled differently. It is as important to prevent a crisis from developing as it is to know the proper ways of controlling one.

Awareness is the key to being prepared for a crisis. Self-awareness refers to understanding how our values and beliefs influence our interactions with young people. We all have a unique way of relating to young people based on our personal background, values, and beliefs about people; experiences as a care worker; the influence of colleagues; and personal interpretations of the institution's goals and philosophy about the treatment of young people.

The most valuable tool we can use in therapeutic interventions with young people is ourselves. We help young people meet their basic needs and have countless opportunities to interact in an open, consistent and caring manner. The person spending the most time with the young people has the most influence on their behavior and growth. How we interact with young people and adults, how we play, work, solve problems, and manage daily tasks presents young people in care with positive adult role models.

#### **What Being a Role Model Means**

Care workers provide an example to young people or how to be a man or a woman, how to show affection, how to solve problems, how to resolve conflicts, etc. Modeling shows them different ways to interact and solve problems. Many young people in care have learned that self-control and self-disciplines are not important. Some adults have shown them that the appropriate response to anger or frustration is to lash out or manipulate.

By encouraging young people to develop relationships with us, we can better influence their lives. Young people choose the adults they are close to as their role models. That adult becomes someone whom the young person watches and tries to emulate. The young person will "try out" the adult's behavior in different situations, including the way they adult handles stressful situations. How we behave will affect how the young people in care will behave.

#### **How Cultural and Ethnic Issues Can Influence Working With Young People**

Very often in agencies the ethnicity of workers is not reflective of the ethnicity of the young people in their care. While we cannot change our ethnic or racial backgrounds, a therapeutic use of self in this situation might require us to pursue

involving young people in activities with their ethnic communities and making sure that those ties are not broken.

Cultural diversity enhances a living environment. Our attitudes and actions should encourage the sharing of cultural heritage and diversity. This can provide young people and the adults in their lives many opportunities for growth and understanding.

### **How Personal Experiences Can Influence Working With Young People**

People become involved in residential care work for a variety of reasons. We may identify with the young people and families we serve or we may have been strongly influenced by an adult when we were growing up. The job might be a step toward a career in psychology. Our personal experiences can enhance or detract from our ability to be empathic and objective. Some of us may have been mistreated as young people, or raised in homes where there was violence, or where there were substance abuse problems. Some of us may have been raised in foster care or in residential placements – experiences that may have been positive or negative.

These reasons alone don't make for good or bad care workers. What is important is whether we have dealt with these experiences so that they don't get in the way, but rather enhance our work with young people and families. For example, a care worker who had been sexually abused as a young person may have empathy for a young person in the same situation, and be able to develop a supportive relationship. But that same worker may also have extreme anger at the person who perpetrated the abuse, which may interfere with an ability to interact with the young person's family.

The message is not that adults who were abused as young people cannot work with young people – quite the contrary! The point is that the therapeutic use of ourselves in the role of care worker requires some introspection regarding our ability to handle situations similar to painful past experiences and a willingness to get help if we can not honestly say that the past is “finished.”

Residential work can be very intense at times and can bring up painful memories. We must make sure that we deal with these memories somewhere other than with the young people and families we are serving. Our life experiences do affect the way we work with young people and families.

## **IV. The Importance of Knowing the Young Person: What Does This Person Feel, Need, or Want?**

### **Knowing the Young Person**

In addition to self-awareness, awareness of the young person is important in therapeutic crisis intervention. This includes knowing the young person's past history; patterns of behavior; and characteristic ways of responding to stress, limits, and

authority. It is also important to have an understanding about the developmental tasks important to the young person. For example, when working with adolescents, it is crucial that we understand what is “normal” and what is “potentially damaging” behavior. It is our responsibility as professionals to learn what we need to know about our clients in order to best meet their needs and not punish normal behavior.

Just as our values, attitudes, and behaviors were influenced by the way we were raised, so too has each young person been influenced. In order to respond appropriately to a young person’s behavior, we need to be able to understand the reasons for their behavior. Unless we have some idea of why the young people act or react the way they do, it’s very difficult to react appropriately. All behavior has meaning. It is our job to be able to find out what meaning is behind the behavior the young person is exhibiting.

Where do we learn how to behave? How do we learn to relate to others? How do we know what to do in certain situations? We may have seen our parents or friends act a certain way and feel its O.K. to do the same. Or, we may have found that by acting in a certain way our needs were met. Just as we have learned ways to get our needs met, so have the young people in our care. Their present behavior is the only way they know how to act.

By knowing a young person’s history and the dynamics of the young person’s present behavior, we can respond in the most effective, therapeutic manner.

### **Behavior Reflects Needs**

Behavior and needs go together. Behavior is an expression of need or an attempt to meet a need. For example, the behavior of a bully may hide feelings of insecurity, a runaway frequently feels afraid of something, stealing may mean envy or jealousy. Whatever behavior we see in young people, we can be sure that it is closely related to a need of some sort. That need should be our primary concern, rather than simply the young person’s behavior.

Think for a moment about how we get our needs met. When we’re feeling lonely, how do we deal with it? Do we just sit and say, “I’m lonely”? More likely, we may call a friend, cry, get sick, or even get angry and lash out at someone. Maybe we feel sorry for ourselves and withdraw in silence. Young people who grow up in stressful environments may have to go to extremes to get their needs met. They have learned their “coping behavior” in order to survive. It has protected them and they will not give it up willingly. If they do not have successful alternatives that are realistically within their abilities to use, they will continue using old patterns of behaviors. It is our

responsibility to help young people develop new coping skills and ways to meet their needs that are successful and within their reach.

### **Types of Aggression**

Over the years there has been much discussion about the meaning of aggression. For the purposes of crisis management, it helps to identify two main categories of aggression:

(a) reactive aggression (motivated by fear and frustration), and (b) proactive aggression (motivated by manipulation and intimidation). Reactive aggression is usually a response to something that has been done to the young person (i.e., a push). Proactive aggression may be described as aggression aimed at getting something from someone (i.e., a pull).

Reactive aggression generally suggests a loss of control and emotional flooding, and is the most common form of aggression, particularly in out-of-home settings. The young person is overwhelmed by emotions and is reacting to a stimulus. The person's physical appearance may be red-faced and wide-eyed, highly aroused. The person will be disorganized, impulsive, and loud.

Proactive aggression includes what is sometimes called the instrumental or operant aggression. There is a goal for the aggression, which usually involves manipulation or intimidation in order to achieve an objective. The aggressor is not out of control, but very much in control. This young person may appear impassive or may even be smiling and smirking. The young person is deliberate and controlled, and his or her tone of voice may be menacing and calm. This is why the development of Individual Crisis Management Plans (ICMP) is important in the treatment of aggressive young people. The ICMP should include a personalized functional analysis of the young person's crisis behavior, including an assessment of the function aggressive behavior serves for the young person. The type of aggression is an important element to consider when intervening in a potential crisis situation.

### **Identifying a Young Person's Needs**

In order to identify the young person's underlying emotions or needs, working with team members is most effective. Very often social work and clinical staff have information about the young person's history and present functioning that can help us identify the maladaptive behaviors, put them into perspective, and assist the young person in developing alternative behaviors. Also, we must trust ourselves. We all have our own experience with young people – use it! We've already discussed the value of asking ourselves four silent questions when dealing with a young person in crisis. Let's elaborate now on the second question: What does this young person need or want? To answer this question we should ask ourselves:

1. Why did this happen today, but not yesterday?
2. Is this typical behavior for this young person?

3. Is the young person expressing a need?
4. Is this normal for a young person of this age?
5. Does this behavior reflect a family or cultural belief?

Again, getting some answers to these questions will help us to respond to what is really going on with the young person, rather than getting hung up on the specific behavior alone.

## **V. Awareness of the Environment: How Is the Environment Affecting the Young Person?**

### **The Importance of the Environment**

One of the most important aspects of crisis prevention is the structure of the program, the management of the environment, and the culture of the organization. Very often the causes of the young people's challenging and inappropriate behaviors lie within the structure and management of the environment. By addressing these influences, the numbers of critical incidents can be greatly reduced.

The organizational culture plays a key role in setting the tone for not only how challenging behavior will be addressed, but what behaviors will be tolerated. In order to promote therapeutic programming and interventions, the culture must value and support developmentally appropriate practice over expediency and control.

Young people must be well informed and involved in decisions affecting their lives. Information is power and young people need to feel powerful and in control. It is important for all young people to have a say in their treatment and access to family.

Appropriate placement of young people in a group and a program is essential for positive growth and development. The program must meet the needs of the young people as well as the group. Staff must be informed about individual treatment plans and trained to work with individuals and groups. Good relationships between staff and young people will create an atmosphere of caring and support.

### **The Physical Environment**

The physical environment surrounding the young person in the institution can have a profound influence on the young person's behavior. A young person coming into residential care is entering a different culture. We must maintain our sensitivity to every person's background and help the young person integrate into the new "culture" while maintaining ties to home.

The way we maintain the environment tells a story, not only about how we care for the young people, but also how we create an atmosphere that is safe and conducive to self-discipline and nurturing. The way the environment is set up can contribute to or detract from the possibility of crisis. Messy, disorganized living spaces, with loud

noises and a lack of routine are not likely to help young people maintain a sense of self-control. On the other hand, too rigid an environment doesn't allow a young person to be a child – to play and to be comfortable.

To begin with, the immediate setting – where the young person lives – can contribute to or discourage acting out. Cleanliness and the appearance of the living space sends a message about what is expected and what is and isn't tolerated. A dirty, messy, unkempt environment acts to lessen one's self-control. (An observation worthy of our attention is our work with young people who already have problems controlling their impulses.)

Remember that many of the young people and families we work with are overwhelmed and their environment is a reflection of this. Young people may also come from a family environment in which abuse or violence is a coping mechanism. The young person may try to recreate that environment in the treatment setting since that is what is normal and comfortable for that person.

A disorganized environment communicates an attitude that anything goes. We all know the environment creates expectations in behavior. We should look around our environment – our group home, our unit, or our dormitory – and ask ourselves, what does it communicate about expectations for behavior?

Leaving objects lying around may also have a stimulating effect on behavior. These objects may also be used as weapons in a volatile situation. For example, do we leave the cue sticks and balls on the pool table when not in use? Take a good look at the everyday objects the young people handle.

1. Can they be turned into dangerous weapons? Can we make them safer?
2. Can we use plastic coat hangers instead of metal, plastic water pitchers in place of glass?
3. Can we make our environment safe without "institutionalizing" it?

There are many, many more objects that can be scrutinized for their potential danger in a volatile situation. It is our responsibility to be aware of the environment and to make it safer, easier to function in, and less prone to escalating a crisis.

Other elements in the environment that can have a stimulating or calming effect on youngsters are lighting and noise. Bright, harsh, ceiling lighting is more stimulating than soft lamp tables. Trying to study in a room with inadequate lighting adds frustration to an already difficult task. Likewise, the noise level in the cottage can contribute to the overall tranquility or excitement of the group. Holding a group

discussion with the television on or the music blaring makes a statement of the importance of the meeting. Fritz Redl, a noted residential treatment worker and author, describes the ingredients of a therapeutic milieu or environment as:

- a house that smiles;
- props which invite, and
- space which allows.

This means that the physical environment should be comfortable, have appropriate furnishing for young people, and adequate space for activities.

### **Activities and Routines That Satisfy and Meet Needs**

Another important aspect of the environment to consider in preventing crises is the type of activities and programs young people are engaged in throughout the day. The day's events, from waking to bedtime, make up a young person's life experiences during placement. Because all young people are greatly influenced by their life experiences, the daily activities in the agency milieu can stimulate crisis situations and acting out if they are not carefully thought out and analyzed for their therapeutic value to each young person. By carefully considering the special problems and needs of the young people in our programs, the day's events can be used to increase coping abilities, strengthen defenses, prevent frustration, and increase self-control.

### **Agency Policy and Procedures**

Lastly, knowing the agency's policies and procedures for dealing with crisis situations is essential in responding to emergencies quickly and appropriately. Before a crisis develops it is critical to know:

1. How do I get assistance in crisis?
2. Whom do I call?
3. Are policies different at night or on weekends?
4. What is the role of the outside authorities?
5. What policy do we have regarding intervention to prevent a young person from running away?

Knowing the answers to these and other important agency-related procedures for dealing with crises is a great help in knowing how to best respond.

## **VI. Intervention Approaches: How do I Best Respond?**

### **Awareness is the Key to Crisis Control**

When dealing with young people who are upset and in crisis it is important to ask ourselves: could things have been done differently? Sometimes, things could have been handled differently. It is as much our responsibility to prevent a crisis from developing as it is to know the proper ways of controlling one.

Awareness is the key to being prepared for a crisis. This training focuses on three areas of awareness: self-awareness, awareness of the environment (which includes the group and programmatic concerns as well as the physical environment), and awareness of the young person.

Self-awareness refers to understanding how our values and beliefs influence our interactions with young people. Our responsibilities include setting goals that will enable young people to make appropriate behavioral and attitudinal changes. It is, therefore, very important to become aware of our personal preferences in interacting with and intervening with young people.

Each of us has a unique way of relating to young people based on our personal background; our values and beliefs about people; our experiences as a care worker; the influence of colleagues; and our interpretations of the institution's goals and philosophy about the treatment of young people. Moreover, different interventions work better in different situation with different types of young people and at different times. Knowing our strengths and those of our co-workers can help us decide which is the right intervention for a particular situation.

### **Intervention Approaches**

There are many ways to intervene in any given situation. We will be discussing five basic approaches. No single approach is sufficient in every situation. Different ways of working with young people are more or less effective given the young person, the group, and the situation. It is important to be flexible in our everyday interactions with young people and to focus on different aspects of the situation at different times as a matter of everyday practice. Being aware of our personal beliefs, what the young person needs, when and where the situation is occurring, what the program expectation is, what is being taught, should all be considered when choosing an intervention strategy.

### **Structuring**

This strategy focuses on providing a safe, secure environment for the young person and then using the environment when intervening in a potential crisis situation. The prevention aspect of this approach is based on maintaining the structure of the program. A schedule for bedtime, chores, and meal times, which is adhered to keeps the program consistent and provides a predictable environment for the young people.

Young people who need clear and consistent rules in order to feel safe and cared for respond well to an emphasis on the structure of the program. These young people feel secure when they are in a program with predictable rules and consistent routines that meet their basic needs.

### **Listening**

This intervention strategy is to take a nondirective, nonjudgmental supportive role, focusing on the internal conflicts the young person is experiencing. The emphasis is on the young person as a worthwhile individual with valid feelings and concerns. It is through a nonjudgmental accepting, uncritical approach that we can help the young person deal with embarrassing or difficult feelings without fear of reproach or criticism.

The goal of this intervention strategy is to help young people feel listened to and understood, which helps them cope with painful feelings and situations.

The listening approach uses active listening techniques to encourage the young person to open up and discuss the internal conflicts before being overwhelmed by feelings. It is appropriately used in a variety of situations and is an excellent relationship-building tool. This intervention strategy can also be used to avoid power struggles. By placing the focus back on the young person, the young person who resents authority is not given any “fuel for the fire.” When we use the listening approach, we place ourselves in an equal power position with the young person. Instead of responding to the young person’s words or behavior, the listening approach responds to the emotions and feelings underlying the behavior.

### **Directing**

When young people’s behaviors are inappropriate or over the limits set by the program, we may need to use an approach that focuses on changing the behavior. The directive approach is useful in situations when a behavior can be changed or the young person needs to learn a new behavior. Once the young person is behaving more appropriately and receiving positive reinforcement, the theory is that the young person will adopt these new behaviors.

When young people have difficulty controlling their own behavior, the directing approach is helpful. It brings a sense of control and order to a world that appears chaotic and unpredictable to the young person with poor impulse control. Directing is also very effective with young people who need a lot of direction, discipline, and reinforcement. There are times when this approach is necessary; certainly when safety is the concern. Redirecting behaviors and making directive statements are some of the tools used to help young people choose and learn appropriate behaviors.

### **Relating**

Building relationships is a critical skill that we must develop in order to be effective. Any approach and technique is more effective when executed by a worker who has a relationship with the young person. The closer we are to the young person, the more likely that person is to behave in ways that seek to gain favor or emulate our actions. By developing a relationship with a young person, the young person may want to become more like us and try new behaviors or attitudes that we encourage. Young people who need a role model or someone to admire respond well to this approach.

Young people learn acceptable ways of expressing emotion, anger, or love by observing how we express these feelings.

### **Teaching**

The teaching approach focuses on helping young people learn from experience and uses situations in everyday life as well as crisis situations as opportunities for young people to learn, change, and grow. New ways of coping are learned best through experience and process. Young people are given the opportunity to explore new behaviors, try out things on their own, and then come back and talk about them with us. Also, this strategy involves mutually agreed upon decision-making in terms of the young person's program, by including young people as partners in their treatment.

Young people are called upon to take responsibility for their actions and make choices that will meet their needs without infringing upon others. Change is a result of the adult creating opportunities for learning for young people and they, as a result, learn new, more adaptive behaviors.

## **VII. Verbal Crisis Communication**

### **Responding to Young People**

Sometimes, instead of attempting to understand young people's feelings, we try to cheer them up, minimize their feelings, or solve their problems. This is likely to discourage young people from any further communication. One way or another, the young person has been "put down" and will not attempt to share his or her feelings again. Other times we may inadvertently put up roadblocks to communication, such as interrupting, criticizing, blaming, or preaching. These roadblocks can hurt our ability to communicate and build relationships with young people.

The nonverbal and verbal techniques used in active listening help us answer the second question; What does this young person feel, need or want? The techniques of both nonverbal and verbal communication are geared toward understanding a young person's needs. Understanding can be defined, in periods of stress and upset, as empathy or the sincere desire to know or perceive what a young person is going through – what the world is like for that person right now. This is the listening approach.

Young people who are angry, upset, frightened, or disappointed want, first of all, to have someone understand their feelings. Often, they don't know what they are feeling. Part of our job in understanding young people is to help them know their own thoughts or feelings without making a judgment. Problem solving and advice giving come later - the first task is to understand. This is the primary skill in the listening approach.

### **Nonverbal Techniques**

Facial expression is a key to understanding how the young person is feeling. Our facial expression is just as important for us to be aware of when we are trying to communicate with a young person. We can express our interest to a young person without saying a word through silence, nods, physical closeness, facial expression, and eye contact.

**Silence**

Often we can say more by remaining silent than by speaking. Sometimes people are uncomfortable with silence and feel compelled to fill the void. Very often young people feel companionship during silence, and are comforted by someone being there. When young people need someone to listen to them, sometimes remaining silent and allowing young people an opportunity to calm down, collect their thoughts, and speak when they are ready, is active listening. Young people who are slow or developmentally delayed often need a lot more time to comprehend what we have said and formulate a response. They need silence as they take in information from us.

**Facial Expression**

The face is marvelously expressive. A raised eyebrow or frown is worth a hundred words. It is far easier to convey acceptance or pleasure with a smile than by stating it verbally. Research by Mehrabian indicates that the face carries the largest percentage of meaning in spoken messages during times of upset and crisis: meaning = 55% facial expression + 38% tone of voice + 7% words.

It is not always what we say, but how we express it that conveys the most information. Showing interest through facial expressions is important.

**Tone of Voice**

Control of our voice when we talk to young people is another crucial aspect of crisis prevention. Often, when young people become agitated, the noise level rises in direct proportion to the degree of emotional arousal. As adults, we react by getting louder ourselves to make sure young people can hear us. When we do this we are acting as a stimulator and escalating the crisis situation. The ability to speak in a calm respectful, non-threatening tone is critical if our goal is to de-escalate by reducing stimulation.

Remember, the tone of our voice has meaning over and above our words. A tone of voice can carry the warmth of intimacy or the coldness of a command. Likewise, fast speech can convey nervousness, whereas deliberate and slow speech conveys calmness. This may be culturally specific. We may need to understand what rapid speech means to a particular culture.

**Eye Contact**

On the face, our eyes relay the most information. Therefore, an awareness of what we are communicating (and receiving) through eye contact is crucial. Establishing eye contact at the beginning of an interaction conveys our interest and our undivided attention. Prolonging such contact, however, may make young people apprehensive and defensive if they feel we are staring at them. It is also important to be aware of

the effect of prolonged eye contact, since it is a physical and emotional stimulator. Varying our gaze away from the young person can prevent this kind of stimulation.

### **Encouraging and Eliciting Techniques**

We can use the following techniques to encourage the young person to talk and to elicit information.

#### **Minimal Encouragements**

Minimal encouragements are brief statements that urge young people to continue speaking (e.g., “uh-huh” “go on” “I see”). If young people are comfortable expressing themselves, we may not need to say very much at all. Our goal in using active listening with upset young people is to keep them talking. Minimal encouragements may be all that is needed. If we try to say too much, we may distract young people from what they are trying to express.

#### **Door Openers**

“Door Openers” are invitations to the young people to speak (e.g., “I’d like to hear more” “Tell me about that” “Do you want to talk?”). Sometimes a young person may say something that we feel is an important issue. We can invite the young person to expand on that point by using a “door opener.”

#### **Closed Questions**

Closed questions have specific short answer responses, such as “yes,” “tomorrow,” “my sister,” etc. Closed questions ask for a minimal response and are appropriate for gathering factual information. The danger in using closed questions is that they may result in young people feeling defensive, angry, or resistant to further probing.

#### **Open Questions**

Open questions, on the other hand, are questions that encourage young people to explain further, to provide us with more information and expand on the expression of feeling. Open questions broaden the discussion. Open questions generally begin with “how” and “what” (e.g., “How do you feel?” “What happened next?” “What do you think about that?”).

#### **Why Questions**

Often questions beginning with “why” elicit a defensive response. They may be seen, not as an attempt to gather information, but as a challenge or a prelude to an attack. They may be perceived as calling for a justification. Our tone of voice can be crucial when asking a “why” question. For example, there can be a world of difference in meaning based on the way the question, “Why do you feel that way?” It can be perceived a put-down if the implication is that one shouldn’t feel that way, or it can

come across as a sincere attempt to understand a young person's feelings. Remember, 38 percent of the meaning of a message is conveyed in the tone of voice. This is important to remember in any verbal interaction, not just when asking "why" questions.

### **Reflecting Techniques**

Verbal techniques that reflect and validate what young people have expressed, communicate that we are listening and understand. Reflecting techniques help young people de-escalate and sort out what they are feeling.

### **Reflective Responses**

Reflective responses mirror what the young person is saying or feeling. For example, "You're really upset with Sara" or "So you want to quit the team" are reflective responses. These techniques reflect the content of a conversation or an individual's feelings back to the young person. It is the way of communicating, "I hear how you feel." Reflective responses indicate our desire to understand young people's feelings, thoughts, and actions without judging, advising, agreeing, or criticizing. We also use reflective responses to validate and affirm what the young person is feeling (i.e., "I would be angry too, if my home visit were cancelled.").

If we are accurate in reflecting back what we heard, this will encourage the young person to continue speaking. Remember, reflective responses are statements back to the young person about what the young person has just communicated; they are not questions. It is also important to reflect the intensity of the feeling. To maximize, or even worse, to minimize the intensity of the young person's emotion, can be a put-down and can shut down the communication process. To say to a young person about to explode and who's just said "I hate that staff!!", "You're feeling a little unhappy with Mr. Smith" sounds insincere, uninterested, and can make the young person angrier!

### **Summarization**

Summarization is helpful for both parties to understand the conversation. It gives feedback after the young person has continued to talk for some time. It helps pull together thoughts and feelings already expressed. The summary also helps us clear up any confusion about what the young person is trying to say (e.g., "Okay, let me see if I understand all of your concerns. You are starting a new job and you aren't sure what to expect. You're pretty hopeful, but you've got a little doubt in your mind and it keeps nagging at you. At this point, you want to talk to your new boss, but are concerned about his reaction to you.").

### **Active Listening**

In order to make appropriate responses, we have to listen. All of the techniques, from nonverbal indications of interest to reflective responses, are a means of gaining

understanding. The first step is to be able to identify what young people are feeling and then communicate to them that we understand how they are feeling. Young people often have a limited understanding of their own emotions; for example, they may just say they are happy, sad, scared or mad. Active listening helps them identify what else is going on (e.g., “You seem frustrated, disappointed, proud, delighted, excited, etc.”). It can identify positive as well as negative emotions, and help young people learn to express the good parts of their lives.

Through active listening we let young people know that we care about what is happening to them. To illustrate that care, we need to be clear about what is going on. Active listening encourages upset young people to communicate their needs so that they talk out rather than act out.

Active listening is not throwing up roadblocks or problem solving. It is not an opportunity to argue facts. We are not necessarily giving permission when we actively listen. If done well, it doesn't sound like parroting and it isn't necessarily time consuming.

Active listening communicates an attempt to understand a young person's feelings and problems, which builds trust and a close personal relationship. It represents the listening approach. Active listening is a way of responding to the young person's feelings rather than simply to their behavior in order to identify what the young person feels, needs, or wants.

## **VIII. Behavior Management Techniques**

### **Behavioral Intervention: Historical View**

Some of the very early work in behavioral intervention techniques remains some of the very best work. Fritz Redl and David Wineman wrote of their work at Pioneer House in Detroit, Michigan during the 1940's and 1950's in: *Controls from Within: Techniques for the Treatment of the Aggressive Child*. The following material is adapted from that book, which was first published in 1952.

There are ways to “interfere” at the triggering and escalation phases of crisis with a young person who is beginning to act out, but who is by no means at the point of being a danger to himself or to anyone else. The idea is to interfere at the “warning signals” or the initial behaviors, to stop the escalation process and to help the young person return to normal functioning.

Paying attention to nonverbal communication, both in terms of the meaning our nonverbal communication has to young people, as well as to their nonverbal messages, is critical. Carefully observing the nonverbal cues of the young people in our care can provide us with valuable information. In this respect, we are using

nonverbal communication as a “diagnostic tool.” Frequently, the only accurate information we receive in an intense or highly charged situation comes by way of the young person’s nonverbal communication. Relying solely on a young person’s words can be misleading. Attending to all aspects of behavior – verbal and nonverbal – is important in responding to the young person.

The need to be aware of nonverbal communication includes a sensitivity to cultural differences among the young people and workers. While it is absurd to interpret a particular gesture or action on the part of a young person as always “meaning” a certain feeling or intent, being aware of the individual’s cultural background can help us to continue to respond in the most timely, therapeutic way. Being sensitive to racial or cultural differences among young people can prevent us from over-reacting, misinterpreting, or ignoring what they are communicating – verbally and nonverbally.

### **Managing the Environment**

We must be aware of and manage the environment as a low arousal behavior management technique. The way in which the environment is arranged sets the tone for the interaction. For example, where we choose to talk with a young person, whether we sit or stand, and who we sit next to are all part of managing the environment.

Imagine what it feels like to walk into a courtroom where the judge is sitting high above the rest of the people behind a bench and wearing formal clothing. This example illustrates the power of managing the environment. An environment can be structured to set a warm, informal, friendly tone, or it can set a cold, businesslike, authoritative tone. Each has its place; it is important that we be aware of the tone we set and that we manage the environment to help prevent or de-escalate a crisis. For example, bringing a young person into the office to talk conveys a very different tone than going to that person’s room to talk. Moving others away from an upset young person can de-escalate the situation.

### **Prompting**

Prompting is signaling to the young person to either begin a desired behavior or to stop an inappropriate action. This can be done verbally (e.g., “It’s about time to put the game away”) or nonverbally (e.g., with a glance or nod which reminds the young person of what is expected). It is a simple, non-critical direction given when the young person needs help in taking the next step.

There are several ways of verbally prompting a young person. We can use gentle reminders, such as, “Dinner will be ready in 10 minutes,” or “Lights out in 15 minutes.” Sometimes we can help young people remind themselves by asking them a

question, “What happens at 5:00?” or “Do you realize how loud the music is?” We may even ask the young person to repeat a rule or an agreement. “What is the rule about doing homework?” or “Do you remember the agreement you made with Karen yesterday?”

Nonverbal prompts include signs or checklists relating to desired behavior displayed throughout the room. Posters can also remind young people of qualities and attitudes they are striving to achieve.

To stop inappropriate action, it is helpful to know what a young person’s “warning signals” are (e.g., a young person may begin to tap the table or kick furniture when experience anxiety). We can then verbally prompt or remind the young person, “It looks like things aren’t going well. Do you need to go to your room for a little while?”, or “Sharon, do you remember the plan we developed that gave you alternatives when you are feeling this way?” This technique often employs the listening approach. It is supportive and non-threatening, simply reflecting what the young person appears to be doing or feeling without criticizing.

Nonverbal prompts that help stop young people from continuing inappropriate behaviors include hand gestures and facial cues. Raising one’s hand is a call for attention; eye contact, facial expressions, and coughing can be used to remind young people of what they should be doing.

A prompt should be given only once or twice. It is not nagging, which is a constant unpleasant urging or scolding. Prompts should be given pleasantly as privately as possible, calmly, and non-critically.

**Caring Gesture (Hypodermic Affection)**

Affection helps increase a young person's self-esteem. Often, when young people are being most difficult, we can look past the behavior and determine the need that is behind the behavior. Sometimes the behavior is coming from insecurity, fear, or anger at life circumstances. At these times, an additional shot of affection and caring may be what the young person needs in order to cope with the problem at hand instead of going to pieces. This may be the time when the young person most needs to hear that we care.

Affection consists of expressing warm feelings of liking and caring for a young person, such as, "You know, I really like you," or "I care about what happens to you." We let young people know that we care about them as human beings even if we don't like the behavior we're seeing. Nonverbal expressions of caring include a pat on the arm, a quick hug, or a special treat.

Some young people may have trouble with the direct expression of interest or affection (for a variety of reasons) and may need a more subtle application. For example, we might involve the young person in a game or ask the young person to explain something. Expressing approval, such as saying, "Good job!" while patting the young person on the shoulders communicates that the young person is valuable and likeable.

Expressions of caring and affection must be genuine and sincere. Both children and adolescents have a need for consistent affection. Don't overwhelm them with praise one moment and then show indifference and coldness the next. Affection increases the young person's desire to identify with the caring adult and to emulate the adult's behavior and values. This technique draws on the relating approach, relying on the relationship as a means of support for the young person.

**Hurdle Help**

Young people may begin to "blow" in the face of an overwhelming task. They may feel that too much is expected of them and that failure is imminent. Rather than laying down the limits and insisting on cooperation, it is sometimes better to give them a little help through the first few steps of the task or over the stumbling block. This doesn't mean doing the task for them! It does mean getting young people started and offering assistance so that they can continue on alone. For example, if a young person displays a lot of resistance when faced with solving a puzzle, it may just be that the person cannot figure out where to begin. By guiding the young person through the first step of the puzzle, we can help the young person to continue on alone, knowing now where to begin.

This technique is best used when a young person's frustration comes from a problem-solving block and not from some other, more serious problem. This

intervention is often used in conjunction with the teaching and relating approaches. We are creating opportunities for learning and making sure young people can use the opportunity without becoming overly frustrated.

### **Redirection**

Redirecting the young person or group or changing the activity (e.g., moving from the kitchen to the living room) may be enough to help a young person calm down and return to normal functioning. This method of diverting and redirecting a young person's energy and attention to a substitute activity can de-escalate the situation and help the young person maintain control.

Redirection may be used in a variety of ways. We can turn a young person's attention from an undesirable or inappropriate activity to one that is neutral or more socially appropriate. For example, asking a young person who is becoming involved in an argument with another young person, whether he or she would like to help prepare dinner or go out to play basketball might defuse the situation. This is a particularly effective technique with a group when the dynamics are such that the whole group is about to erupt. By changing activities, the group's energy is redirected.

We can also use redirecting by interrupting the behavior with a distraction. Asking a simple question, "How did you do in school today?" or making a simple request, "Could you go get me the paper?" may be enough of a distraction to interrupt the inappropriate behavior.

### **Proximity**

Proximity means nearness. Often the mere fact of having us close by will be calming for a young person. When young people are having difficulty staying on task or playing with others, sometimes our mere presence can give them the needed support to stay in control. Teachers often use this technique to maintain order in a classroom without calling attention to or singling out a young person. The teacher simply moves closer to the young person who is struggling to stay in control.

Where we stand in proximity to young people affects the interaction. Standing or sitting between two young people who are angry with each other provides a buffer and barrier to break the tension. Approaching an upset young person from the side versus the front is less confrontational. Standing, instead of sitting, places us in a more powerful position. If we are comfortable using the directing approach, we usually use this intervention technique very effectively. Stationing ourselves near young people reinforces the sense of control and security established through the directing approach.

Touch can also be a powerful intervention. A hand on the shoulder or arm may provide the assistance young people need to get back on track. Simply touching the young person is a reminder that we are there and available for help. Offering a “helping hand” often provides the additional support the young person needs to remain in control. This technique is used very effectively in conjunction with the relating approach.

Of course, the use of touch requires knowledge of how the young person will interpret the touch. A young person who has been repeatedly physically abused may perceive a touch as the beginning of an abusive episode, and what was meant to de-escalate may totally escalate the situation. A young person who has been sexually assaulted may misperceive the intentions of a touch. If we have any doubts, or we don’t know a young person, it is best to refrain from touching until we’re sure they will see it as helpful rather than intrusive or threatening. It is also important never to touch a young person who is angry. This will more often than not escalate the situation. If young people are upset and angry, the natural response may be to pull away or strike out at us if we touch them.

### **Planned Ignoring and Positive Attention**

Although all young people desire attention, some young people believe they only belong and are important when they are receiving attention. This results in constant attention-seeking behavior which often meets with negative attention. For these young people negative attention is better than no attention at all. There are many ways we can respond to a young person’s attention-seeking misbehavior. Some of the best methods are proactive. These techniques set aside time for young people to receive the attention they need in a planned and positive way.

Planned ignoring is a slow but very effective way of eliminating harmless, attention-seeking behavior. We must size up which behavior will fade out on its own if ignored. Ignoring behavior withholds the reinforcement a young person gets from the attention. Be sure that this is behavior which can be safely ignored (i.e., that it is not dangerous to the young person or others). It is important to distinguish between behavior that can be safely ignored and behavior that is escalating into a serious problem that requires direct adult intervention.

Along with ignoring the undesired behavior, we must give positive attention for the appropriate behavior. For example, if the young person is asking permission to speak versus interrupting conversations, reinforce the good behavior – asking permission. When using planned ignoring:

1. stop speaking to the young person;
2. adopt a neutral facial expression;
3. look away from the young person’s face (but remain vigilant);

4. avoid touching the young person.

It is critical for everyone to work together to use planned ignoring successfully. Be sure that everyone involved can tolerate ignoring the behavior without eventually giving in or punishing the young person. Generally, young people respond to planned ignoring by escalating the problem behavior or it will be further strengthened by intermittent reinforcement. Everyone must also know what the “appropriate” or “substitute” behavior is that is going to be reinforced. All must praise the appropriate behavior and give the young person positive attention when it is being used. These two techniques combine the intervention approaches of directing and relating.

Planned ignoring combined with positive attention is an effective method of eliminating problem behaviors. It requires a lot of patience, teamwork, and determination. Experience and careful observation will assist with this.

### **Directive Statement**

When stress and upset escalate and the ability to make rational decisions decreases, it is necessary to provide young people with direct guidance. Directive statements tell young people in specific terms what is expected. These statements range from requests, to a statement of rules, to demands.

We should phrase these statements in positive ways whenever possible. For example, “Talk in a quiet voice,” is requesting the desired, positive behavior rather than “Shut up,” which is negative. Request what young people should do rather than what they should not do. If a request will suffice, do not make a command. If a young person can still respond to “Please go to your room and cool out,” don’t demand that the young person leave the room, “Go to your room right now.” This avoids the feeling of being “ordered around.”

Directive statements should be clear and specific and should not be confused with prompting. The limit should be stated in a clear and assertive manner. It is not a question and it is not a conversation. The less talking the better. “It’s bedtime!” is better than “You know that bedtime is at 9:00. I want you to go to bed right now and stop playing around. Are you going to go or what?” If the young person has no choice in the matter, do not ask a question. Another way to guide the young person to the appropriate behavior and depersonalize the situation is to restate the rule, “The rule is, lights out at 9:00.”

If a young person continues to behave inappropriately and is not responding to direct requests or appeals, it may be necessary to assert authority and make the decision for the young person. This calls on the use of the directing approach. The desired behavior must be stated clearly and assertively (e.g., “Come back to the table and sit down.” or “Put the game away and go to your room.”).

### **Time Away**

Requiring young people to go to a quiet area, such as a bedroom, when they are upset and being stimulated by others is often a good strategy. Young people can regain their control in an area where they can calm down and think. Younger children may simply need a few minutes alone to realize that they are missing out on the fun and attention of others. A few minutes away can be used to remind them of the behavior expected of them if they want to participate with the group. They should rejoin the activities as soon as they are able to participate appropriately. They should receive praise for being quiet and taking some time away, and for behaving well once they rejoin the activities.

Young people can use some time away to regroup and think about what happened in addition to calming down. After a few minutes, they should be ready to discuss what happened and plan how better to handle frustrating experiences. Again, all young people should return to the group as soon as possible. This technique focuses on the escalating behavior and uses the directing approach to direct young people away from the stimulus and gives them time to regroup and return to normal functioning.

### **Summary**

Behavior management techniques are not, in and of themselves, problem-solving techniques. They are methods we use to stop escalating behaviors and to help the young person regain control. Once young people are back on track, we can use communication and problem-solving skills to help them learn better ways to handle stressful situations.

## **IX. Anger and the Crisis Cycle**

### **Normal Feelings and Emotions in Care Work**

When we work with young people it is normal to feel frustrated, disappointed, and even angry at times. The literature is full of warnings to remain relaxed and in control of our feelings when dealing with challenging young people's behaviors. This is not easy! To wrestle both with the young person's behavior and with the feelings it arouses in us is not an easy task.

Feelings are difficult to discuss. For everyone, anger is one of the strongest emotions generated when young people in care act out. This prompts the question: What can we do in order to maintain control of our feelings in a crisis, to channel our feelings in a direction that will not interfere with an effective response to the situation?

### **Managing Our Feelings**

When faced with a difficult situation, it's important to return to the question, What am I feeling now? The goal in handling crisis situations is to address the young person's

needs while keeping in mind agency policies, the effects the young person may be having on others, and the role the environment is having on the outcome of the crisis.

Response to a crisis situation demands objective and accurate assessment. Anger can undermine objectivity. How can anger in a crisis influence our ability to respond objectively? Anger is an emotional and physical state. When we are angry our emotional energy is high and tension builds to an uncomfortable level. Concurrently our coping or thinking ability is low. We lose the ability to reason and think clearly. In other words, “When we are at our angriest, we are at our stupidest.”

It is important for us to identify our emotions during a crisis in order to control our behavior. When we’re angry, we are more likely to act on “instinct” which could provoke an inappropriate response. By being conscious of our anger we may be better able to evaluate the situation. Knowing what can trigger our anger and recognizing a situation that “pushes the wrong buttons” can help us regain our composure and address the young person’s behavior in a manner that will de-escalate the situation rather than escalate it. Our reaction to the young person should include controlling our “buttons” that the young person is pushing.

In stressful situations when a young person pushes our buttons, we should acknowledge that we are allowing ourselves to get angry. We are in a stressful situation with a young person who is behaving in a way that is a trigger to us. Our anger is then fueled by our thoughts and our negative self-talk in these situations: “He should know better.” “He has no respect for me.” “He is trying to drive me crazy.” The young person is not making us angry. We are stressed and our thoughts and negative self-talk are fueling the fire. We can change our thoughts and our self-talk in order to maintain our objectivity and rational thinking abilities.

Young people coming into care often have violent backgrounds and may have learned how to elicit anger. Having been victims of abuse, they may invite abuse – not because they like it, but because it is a familiar pattern of behavior for them. This requires even greater awareness and preparation on our part to ensure that the outcome of a crisis with a young person is a safe and therapeutic one.

### **The Crisis Cycle**

It is important for us to reflect on the times when we have gotten angry, how we felt, what we told ourselves, and how we could have handled the situations differently. Our anger can cloud our judgment and cause us to respond inappropriately and, often, ineffectively. The loss of our ability to think clearly is the same as the young person’s inability to cope in a crisis! Our own anger, if unchecked, can cause us to be in crisis as well! When we feel ourselves getting angry, our first task must be to defuse and lower our emotional energy. We can do this by changing how we think about what triggered our anger, what we are doing to discharge the energy, or recognizing what we are feeling underneath the anger.

In order to help young people control themselves and their emotions, we must first accept and then control our own feelings. This is particularly crucial with regard to being angry in a crisis situation, when it is all too easy to act impulsively. Do not counterattack, exchange insults, or debate the facts. Criticism, sarcasm, and blaming will only inflame your anger and the young person's anger. We must stay in control of our emotions and use our best coping skills to manage our anger in order to help the young people in our care.

Young people as well as adults need to feel that they have control of things in their lives. This is especially true for young people in care. So much of their lives has been "out of their control" that they generally feel helpless and powerless. They struggle constantly to take control of stressful situations which often results in endless power struggles with us, the adults in their lives. We can call this type of power struggle a crisis cycle. Because, if this cycle is not broken, it will inevitably erupt into a crisis. When young people are in a stressful situation, their stress level increases (triggering) and they respond in the usual way of coping with painful feelings (escalation). This behavior often provokes a reaction from us which adds to the young person's stress.

To break the cycle, it is essential that we understand and recognize what is happening. In the triggering phase, as previously discussed, an incident occurs which produces stress. The young person does not have healthy, productive ways of coping with these anxieties so the situation moves into the next phase, escalation. During this phase the young person may choose anger and respond with nonproductive or even destructive behaviors. At this point in the crisis cycle we must consider our reactions to the young person. Remember – how we react in intervene helps determine the outcome of crisis. At this stage we need to be in control of our emotions. We must avoid a "trigger thought" about the young person that will feed our anger with negative self-talk. Instead, this is the time to use "positive self-talk" (i.e., "This young person needs someone to listen. I can do that.").

It is important to stop this destructive cycle. We must understand the cycle and not fall into the trap of becoming involved in the escalation of the crisis. It requires self-control and insight to disconnect from the struggle, putting aside our personal emotions and negative self-talk. We must choose to use self-talk that does not feed our anger but focuses on the question, What does a young person feel, need or want? We have an opportunity to engage the young person, problem-solve, or use alternative coping mechanisms by withdrawing from the conflict. If the cycle continues, we will only enrage the young person who may have disastrous results, such as damage to the relationship, decreased self-esteem, destruction of property, and sometimes physical violence.

Good alternatives that we can use to break the cycle include giving choices, withdrawing from the conflict and taking some time away from the situation, asking for some alternative suggestions from the young person, offering help and then waiting.

### **Managing Noncompliant Behavior**

We often find ourselves in situations where the young person is disruptive and will not leave the room or follow our instructions. This situation is often handled by “escorting the young person” from the scene and seems to end up in physical restraint more often than not. Essentially, we end up using physical restraint to enforce program rules or force young people to follow our instructions. This is clearly an inappropriate use of high-risk safety intervention. If the young person is simply refusing to comply with our request to follow rules or to leave the area and is not in imminent risk of inflicting self-injury or harming others, we should use other de-escalation techniques. If the young person is not a safety risk, forcibly escorting the young person is an inappropriate use of force, and will more than likely enrage the young person and set up a restraint.

If the young person is not too angry and is still responding to us, sometimes a touch on the arm or shoulder or the use of proximity will give the young person the support and reassurance needed to walk away or comply. This is using the relating and directing approaches. It should not become a restrictive physical technique. Never touch an angry young person as it is a trigger to violence.

There are many things we can do if we have program support, if we are skilled professionals and have patience. When young people will not comply or leave an area:

1. Actively listen and problem solve. Actively listen to discover and understand what the issue is and then try to solve the problem with the young person. (listening and teaching approaches)
2. Remove the others from the area. Avoid the young person taking a stand in order to “save face.” (structuring approach)
3. Give the young person choices and then time to decide. Avoid a crisis cycle by letting the young person have choices within boundaries that we have set. (teaching approach)
4. Let the program consequences stand. Depersonalize the situation by relying on the program structure. If these consequences, both positive and negative, are not motivating enough to keep young people within the program, perhaps they should be examined. (structuring approach)
5. Redirect the young person to another, more attractive activity. Give the young person a better place to be that will meet his or her needs and avoid a crisis. (directing approach). After the young person is out of the area and back to normal functioning, conduct an LSI to examine what better coping skills and choices the young person might have made. (teaching approach)

6. Appeal to the young person's self-interest. Motivate the young person to comply with the request by pointing out the positive outcome that will follow the young person's compliance with the program. (directing approach)
7. Use the relating approach. This is a method to help the young person save face, (e.g., "I didn't want to do it, but I will do it for you.")

We should ask ourselves, what does this young person feel, need, or want? and then provide verbal support. Our goal in guiding the young person through a crisis is to help the young person maintain control and develop socially appropriate coping skills. If a young person is refusing our directives but is still in control, we should rely on the structure of the program. The program should be used, not force.

## **X. Nonverbal Crisis Communication**

### **Awareness of Nonverbal Communication is Essential**

When dealing with young people who are on the verge of exploding, an awareness of and control over our nonverbal communication is crucial. In many cases, the emotionally aroused young person may not even hear our words, but is responding to other cues. Nonverbal behavior is a constant part of our experience. Paying attention to this aspect of communication, both in terms of what meaning our nonverbal behavior has to young people, as well as what young people's nonverbal messages are, is critical. Carefully observing the nonverbal cues of the young people in care provides us with valuable information.

### **Sensitivity to Cultural Issues**

The need to be aware of nonverbal behavior includes sensitivity to cultural differences among young people. While it is absurd to interpret a particular gesture or action on the part of a young person as always carrying a certain meaning, being cued into the dynamics of young people's cultural backgrounds can help us respond in the most timely, therapeutic way. Being sensitive to racial or cultural differences among young people can prevent us from overreacting, misinterpreting, or ignoring what young people are communicating – verbally and nonverbally.

The need to be aware of nonverbal behavior includes a responsibility to be aware of cultural differences among ethnic groups represented by the young people in care. For example, wearing a hat indoors may be acceptable in some groups and rude in others. What we allow young people to call other adults (i.e., Mr. /Mrs., first name) varies. Some groups shake hands as a greeting while others nod.

### **Eye Contact**

The use of eye contact is powerful and can easily escalate a stressful situation. As described in the material on active listening, establishing eye contact communicates interest and caring. But when a young person is highly aroused, eye contact, especially if it is prolonged, can escalate the situation rapidly. Prolonged eye contact is generally a stimulator and a way for someone to try to take control. In a highly charged situation, we must avoid staring at the young person or demanding that they, "Look at me when you are speaking!" Eye contact also has much cultural content and may be interpreted differently than the adult meant.

### **Body Language**

An important aspect of nonverbal communication is body language, which refers to how people hold their bodies to communicate a variety of messages and feelings. In a crisis, body stance—the position in which we sit or stand, how we arrange our hands and legs, the tilt of our head, and overall posture—is a strong communicator to young people about how calm, confident, and in control we feel. Likewise, a threatening, authoritative stance may serve to escalate the crisis and provoke a volatile response from young people.

Obviously, the situation itself and what the objective is in dealing with young people will determine the type of body stance we adopt in crisis. There are times, for example, when an authoritative stance may be called for in order to establish our authority and our ability to control the situation. When our goal is to be non-threatening and calming to young people, our body language should communicate this message (i.e., we should stand in a non-threatening manner that suggests that we are open for discussion and want to listen).

Along with stance, where we stand in relationship to the young person, is equally important. Placing ourselves face-to-face with a young person may serve to escalate the crisis by blocking the person's avenue of exit and communicating a message of direct confrontation that may be provocative. Approaching from the side and staying off center is a non-threatening position.

### **Personal Space**

We have a different need for personal and public space. Personal space is very much culturally based. The intrusion of a person into our private, personal space can have a great deal of significance in terms of our reaction to the intruder and the subsequent interaction. The more fearful an individual is, the more important that person's sense of personal space becomes. When this space is violated, the individual will become defensive. In everyday interactions people subconsciously defend the intrusion of personal space by backing away. Although perhaps unaware of it at the time, they are saying, "You are coming too close and I am uncomfortable."

Respecting the young person's personal space will prevent us from inadvertently provoking an aggressive or volatile response. Close, but not too close, is the general rule in crisis control. The more anxious the young person is, the greater the requirement for personal space – maybe even the entire room.

### **Height and Gender**

Personal space preferences often vary according to height or gender. An awareness of the effect of a height or gender difference between ourselves and the young person is important. Standing over young people looking down on them may convey an authoritarian message and may be perceived as a threat.

Inviting the young person to sit with us is often an effective way of equalizing the height difference. Putting ourselves at a young person's eye level will also add to the young person's comfort and hence make communication easier. Another advantage of this technique is that if the young person does agree to sit down, he or she may become predisposed to complying with other requests. This simple act of getting the young person to cooperate with us gives us an added element of control in the crisis situation.

### **Controlling Verbal and Nonverbal Messages**

When dealing with an emotional, volatile, potentially explosive situation with young people in care, we can make a contribution by demonstrating that we are in control and will maintain that control until the young people regain self-control. If we respond to young people's increased agitation by becoming emotionally aroused ourselves, we are not in control, and in fact, we are taking our cues from the young people. Being sensitive to what our nonverbal communication is conveying is a critical part of crisis prevention and intervention.

**SUMMARY:** The information provided above should give you many good ideas on how to avoid restrictive interventions (restraints) and defuse a crisis. WE encourage you to complete the full Therapeutic Crisis Intervention (TCI) course to learn more about these techniques and to learn how to properly conduct a restraint. Remember, until you complete the TCI course you are not allowed to restrain a client.

### **System of Care and Strength Based Practice**

North Carolina has adopted a System of Care model to provide child and adolescent mental health services. This model nationwide is considered to be "best practice". The System of Care model has six main principles:

- Community-based;
- Comprehensive, coordinated, and collaborative across agencies and systems;
- Involve families and youth as full partners;
- Culturally competent with respect to racial, ethnic and linguistic differences;
- Individualized, flexible, coordinated and designed to fit each child; and family and
- Strength based.

These materials focus on how to provide services using a strength based approach. Many times our clients and their families resist change feeling that we are judging them, being critical of them and telling them that they need to change. Using a strength based approach defuses many of those issues and instead helps our clients and their families feel that we respect them and accept them as they are and provides a way for them to make progress and move forward.

### **What Do Clients Want?**

According to clients, the best workers:

- Listened
- Cared about them
- Respected them
- Noticed their strengths
- Trusted them
- Didn't give up on them

### **The Strengths Perspective**

At the very least, the strengths perspective obligates workers to understand that, however down-trodden or sick, individuals have survived (and in some cases thrived). They have taken steps, summoned up resources, and coped. We need to know what they have done, how they have done it, what they have learned from doing it, what resources (inner and outer) were available in their struggle to surmount their troubles. People are always working on their situations, even if just deciding to be resigned to them; as helpers we must tap into that work, elucidate it, find and build on its possibilities.

### **Principles of Partnership**

1. Everyone deserves respect.
2. Everyone needs to be heard.
3. Everyone has strengths.
4. Judgments can wait.
5. Partnership is always possible.
6. Partnership is a process.

### **Questions for Eliciting Strengths from Parents**

- We have been talking about some very serious matters. To give me a more balanced picture, can you tell me some of the things that you feel are good about this family?
- If you were describing yourself to others, what sorts of things would you say you are good at?
- What do you like about being a parent? What have you learned from the experience?
- Can you tell me what you like about your dad? What sorts of things do you like doing together?
- What do you like about your son? What would you say he's good at?
- How do you usually solve family problems? Who does what?
- What do you do to cope in times of stress?
- Who do you turn to for help in dealing with problems? How do they help you?
- Who could best support you in dealing with problems? How could they help?
- What do you do to help yourself deal with the pressures of raising children?

- Clearly, things have been really difficult for you. How have you coped with these pressures? What's kept you going?
- How is it that, even though you are faced with all this, you have determined to do the best you can for your children?
- Can you tell me about the times when you got on well with your partner/child? What do you like about those times?
- What do you consider is good and what do you like about your family?
- What is good about your relationship with your child/mom/dad/sibling?
- What do you think they would say is good about their relationship with you?

## Assessments

### Strengths Assessment

What the person wants, desires, aspires to, or dreams about. Information gathered about person's talents, skills, and knowledge. A holistic portrait.

Gather information from the standpoint of the consumer's view of their situation. Ethnographic.

Is conversational and purposive.

The focus is on the here and now, leading to a discussion of the future/past - asking how they have survived so far.

Persons are viewed as unique human beings who will determine their wants within self and environment.

Is ongoing and never complete with the relationship primary to the process. Encouragement, coaching, and validation is essential to the process.

Strengths assessment is specific and detailed, individualizes person.

In conducting a SA, behavior is considered A desire to communicate.

Consumer authority and ownership.

### Problems Assessment

Defines diagnosis as the problem. Questions are pursued related to Problems, needs, deficits, symptoms.

The problem assessment searches for the nature of patient/client's problem from the perspective of the professional. Analytical.

Is an interrogative interview.

The focus is on diagnosis assessment procedures to determine the level of functioning.

The client/patient is viewed as lacking in sight regarding behavior or in denial regarding scope of problem or illness.

Done at set time (often at intake) and largely viewed as complete at that time.

The intent of the problem assessment is to place the person in diagnostic or problem category. Often written in generic, homogenous language.

In a PA, behavior is seen as symptomatology, attributed to disorder.

Is controlled by the professional.

## Two Techniques for Helping Families Develop Their Vision and Goals

### 1. Where would you like to be? What would it look like if things were better?

- Sometimes helping families develop their vision and goals is as simple as asking directly what they would like to see happen. You could ask someone who wants to have a job but doesn't know where to start, "What would you like to be doing in 10 years?"
- It helps to take a long view because that allows time for whatever education, job training, or experience it would take to get there, and lets them think bigger than would be realistic for the next week.
- Then affirm the vision, and follow-up with a discussion of what it might take to get there. What both of you can do to gather information about resources that might help to make it happen, or people in that line of work could be contacted and advice sought.

### 2. The Miracle Question

- Sometimes it can feel to families like it would be a miracle for things to be better, so start there. You might ask:
 

"Suppose while you were sleeping tonight a miracle happens. The miracle is that the problem that has you here talking with me is somehow solved. Only you don't know that because you are asleep. What will you notice different tomorrow morning that will tell you that a miracle has happened?"
- Follow-up with specific questions designed to take attention away from the problem that has you here talking with me is somehow solved:
  - What is the very first thing you will notice after the miracle happens?
  - What might people notice about you the would give them the idea that things are better for you?
  - When someone notices that, what might he/she do differently?
  - When they do that, what would you do?
  - And when you do that, what will be different in your life (or around your house, job)?
- What are you trying to do is to help this person think, in detail, about what will be different in his/her life when this miracle happens.
- As he/she works to describe these differences, he/she may begin to develop an idea that things could change and a sense of the goals he/she wants to set to move things in that direction.
- You will use the follow-up questions to help him/her develop clear, concrete goals that reflect the presence of something, not just the absence of a problem. If he/she says, "I wouldn't be lonely," you could say, "What would you be doing instead?" "What would it look like?"

## Questions for Helping Families Think and Talk About Strengths

### 1. Coping Questions

You can help family members think about their strengths and resources by asking them how they are able to cope with the difficulties they are facing.

- For example, you might paraphrase what a family member has told you about their situation, and say, "I can see that you are dealing with a lot. How have you managed to cope with all this and keep going?"
- She may say at first, "I don't know," and you can repeat your thought, "I'm serious. How do you do it all and keep going?"

- You may get an answer like, “I have to, for my kinds,” which you can respond to by affirming that she must care a lot about them, and ask her to tell you more about them and how she takes care of them. This affirms her strengths and uncovers her motivation to cope.
2. Exception Finding Questions  
Another way to move to a strengths-based discussion is by asking exception finding questions.
- If a single mother has told you how hard it is to keep a job while raising two children, you might ask her to tell you about times when it has worked out, and how she’s done it.
  - Focusing on the who, what, when, and where of exception times can help her focus on her strengths and resources and be motivated to create her own solutions.
3. What’s Better Questions  
One way to begin sessions, after the initial assessment you have done together, is to ask, “What’s better?” or, “What progress can you see?”
- This is similar to the exceptions question in that it helps family members think about positive movement toward their goals.
  - This can work better than starting out with a question like, “So how’s it been going since our last meeting?” Such a broad question may bring up and focus the conversation on problems and set-backs, with a discouraging effect.
4. Scaling Questions  
As you do ongoing assessment, you can help the family recognize their strengths by having them look at where they are on accomplishing their goals compared to where they started.
- One technique is to use scaling questions. You say, “Let’s think about this on a scale of 0 – 10. If 0 is where you were when we started working together on this and 10 is when you’ve reached your goal, where are you right now?”
  - When they respond with a number greater than zero, you can follow up with questions that uncover and affirm strengths, for example, what’s different that tells you you’re getting closer to where you want to be?

## Questions to Assess/Discover OTHER FAMILY STRENGTHS

- What were you like as a kid?
- What were you good at doing as a kid?
- What kind of student were you? Did you like school?
- Tell me about your favorite teacher.
- If you could say one good thing about yourself, what would you say?
- What would other people say? Your family?
- How are decisions made in your family?
- The last time a problem arose in your family, how was it handled?
- Describe the positive interactions in your family.
- What are some of the most important things that have happened to or in your family?
- What are the most important issues that you are dealing with at this time?
- What was different when things were better for your child and the family?
- What was different when things were worse?
- What are the best things about each of your children?
- What are your dreams of your family’s future?

- How did you and \_\_\_\_\_ meet?
- How long have you lived in your neighborhood?
- What are two good things about your neighborhood?
- How do you picture your family five years from now?
- What progress do you see your family making towards your goals?
- If you could meet one goal over the next year, what would it be?

#### **Questions to Assess Strengths of PARENTAL ATTITUDES AND VALUES**

- What do you think your parents thought was most important for you to learn as you grew up?
- What would you like your children to learn?
- What are some of your family traditions? (holiday celebrations, etc.)
- Do you still celebrate them now?
- How would you like to hear someone describe your family?
- Say a few things about family loyalty as it relates to your family.
- Picture your family as you would like it to be. What is each person doing? What roles are they playing in the family?
- On a scale of 1 to 10, where are you now?
- What have you done to get this far?
- What are your family's greatest accomplishments?
- What are you most proud of about your family?
- What qualities do you use to help family in times of stress or hardship?

#### **Questions to Assess Strengths of the EXISTING FORMAL SUPPORT SYSTEM**

- What services are you receiving at this time?
- Which ones do you think are helping your child and family?
- Which ones are you most comfortable with?
- Are people available when you need them?
- Of all the services that you are receiving, who is the person that you find most helpful and dependable?
- Do you feel comfortable with the frequency of contact that you have with the various agencies/services?
- Have you ever had a crisis in your family? Do you know who to call? Did they respond promptly and in a helpful manner?
- Do you think the service providers are working together?

#### **Questions to Assess Strengths of the EXISTING INFORMAL SUPPORT SYSTEM**

- Are you involved in community activities? (church, clubs, sports, scouts, lessons)
- Who is the first person (the child) calls when he/she needs help?
- Who does the family turn to in times of need?
- Do you have family who lives nearby? Do you see much of them? How are they involved with your child and family?
- Who is the first person you call when you need help?
- Who comes to your family's celebrations? (holidays, graduations, reunions, etc.)

**Questions to Assess POTENTIAL FORMAL AND  
INFORMAL SUPPORT SYSTEMS**

- Does your child have interests or abilities that he/she would like to use or learn about in the community?
- Are there things that your family would like to do together?
- What programs and/or activities are available in your community that you would like to be involved with, if you could be?
- Is there anyone in your community that you or your child are interested in getting to know?
- Are there community programs that you know about that you have considered being involved with in the past, but, for some reason changed your mind or weren't able to become involved?

SERVICE DEFINITION TRAINING – PLEASE REVIEW THE ATTACHED SERVICE DEFINITION

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## **1.0 Description of the Procedure, Product, or Service**

Psychiatric Residential Treatment Facilities (PRTFs) provide non-acute inpatient facility care for NC Medicaid (Medicaid) recipients under 21 years of age, and NC Health Choice recipients' ages 6 through 18 years of age who have a mental illness and/or substance abuse/dependency and need 24-hour supervision and specialized interventions.

## **2.0 Eligible Recipients**

### **2.1 Provisions**

#### **General**

Medicaid recipients shall be enrolled on the date of service and may have service restrictions due to their eligibility category that would make them ineligible for this service.

NC Health Choice (NCHC) recipients, ages 6 through 18 years of age, shall be enrolled on the date of service to be eligible, and shall meet policy coverage criteria, unless otherwise specified.

#### **Specific**

PRTF services are available to Medicaid recipients under 21 years of age. Continued treatment can be provided until the recipient's 22<sup>nd</sup> birthday when medically necessary.

### **2.2 EPSDT Special Provision: Exception to Policy Limitations for Recipients under 21 Years of Age**

#### **42 U.S.C. § 1396d(r) [1905(r) of the Social Security Act]**

Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) is a federal Medicaid requirement that requires the state Medicaid agency to cover services, products, or procedures for Medicaid recipients under 21 years of age **if the service is medically necessary health care** to correct or ameliorate a defect, physical or mental illness, or a condition [health problem] identified through a screening examination\*\* (includes any evaluation by a physician or other licensed clinician). This means EPSDT covers most of the medical or remedial care a child needs to improve or maintain his/her health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems. Medically necessary services will be provided in the most economic mode, as long as the treatment made available is similarly efficacious to the service requested by the recipient's physician, therapist, or other licensed practitioner; the determination process does not delay the delivery of the needed service; and the determination does not limit the recipient's right to a free choice of providers.

EPSDT does not require the state Medicaid agency to provide any service, product, or procedure

- a. that is unsafe, ineffective, or experimental/investigational.
- b. that is not medical in nature or not generally recognized as an accepted method of medical practice or treatment.

Service limitations on scope, amount, duration, frequency, location of service, and/or other specific criteria described in clinical coverage policies may be exceeded or may not apply as long as the provider's documentation shows that the requested service is medically necessary "to correct or ameliorate a defect, physical or mental illness, or a condition" [health problem]; that is, provider documentation shows how the service, product, or procedure meets all EPSDT criteria, including to correct or improve or maintain the recipient's health in the best condition possible, compensate for a health problem, prevent it from worsening, or prevent the development of additional health problems.

**\*\*EPSDT and Prior Approval Requirements**

- a. If the service, product, or procedure requires prior approval, the fact that the recipient is under 21 years of age does **NOT** eliminate the requirement for prior approval.
- b. **IMPORTANT ADDITIONAL INFORMATION** about EPSDT and prior approval is found in the *Basic Medicaid and NC Health Choice Billing Guide*, sections 2 and 6, and on the EPSDT provider page. The Web addresses are specified below.

***Basic Medicaid and NC Health Choice Billing Guide:***

<http://www.ncdhhs.gov/dma/basicmed/>

**EPSDT provider page:** <http://www.ncdhhs.gov/dma/epsdt/>

**2.3 Health Choice Special Provision: Exceptions to Policy Limitations for Health Choice Recipients ages 6 through 18 years of age**

**EPSDT does not apply to NCHC recipients.** If a NCHC recipient does not meet the clinical coverage criteria within **Section 3.0** of the clinical coverage policy, the NCHC recipient shall be denied services. Only services included under the Health Choice State Plan and the DMA clinical coverage policies, service definitions, or billing codes shall be covered for NCHC recipients.

**3.0 When the Procedure, Product, or Service Is Covered**

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

**3.1 General Criteria**

Procedures, products, and services related to this policy are covered when they are medically necessary and

- a. the procedure, product, or service is individualized, specific, and consistent with symptoms or confirmed diagnosis of the illness or injury under treatment, and not in excess of the recipient's needs;
- b. the procedure, product, or service can be safely furnished, and no equally effective and more conservative or less costly treatment is available statewide; and

- c. the procedure, product, or service is furnished in a manner not primarily intended for the convenience of the recipient, the recipient's caretaker, or the provider.

### 3.2 Specific Criteria

Medicaid and NCHC shall cover admission to Psychiatric Rehabilitation Treatment Facilities when the recipient meets **all** of the following criteria:

- a. The child/adolescent demonstrates symptomatology consistent with a DSM-IV-TR (AXES I-V) diagnosis which requires, and can reasonably be expected to respond to, therapeutic intervention.
- b. The child/adolescent is experiencing emotional or behavioral problems in the home, community and/or treatment setting and is not sufficiently stable either emotionally or behaviorally, to be treated outside of a highly structured 24-hour therapeutic environment.
- c. The child/adolescent demonstrates a capacity to respond favorably to rehabilitative counseling and training in areas such as problem solving, life skills development, and medication compliance training.
- d. The child/adolescent has a history of multiple hospitalizations or other treatment episodes and/or recent inpatient stay with a history of poor treatment adherence or outcome.
- e. Less restrictive or intensive levels of treatment have been tried and were unsuccessful, or are not appropriate to meet the individual's needs.
- f. The family situation and functioning levels are such that the child/adolescent cannot currently remain in the home environment and receive community-based treatment.

### 3.3 Continued Stay Criteria

All of the following criteria are necessary for continuing treatment at this level of care:

- a. The child/adolescent's condition continues to meet admission criteria at this level of care.
- b. The child/adolescent's treatment does not require a more intensive level of care, and no less intensive level of care would be appropriate.
- c. Treatment planning is individualized and appropriate to the recipient's changing condition with realistic and specific goals and objectives stated. Treatment planning should include active family or other support systems involvement, along with social, occupational and interpersonal assessment unless contraindicated. The expected benefits from all relevant treatment modalities are documented. The treatment plan has been implemented and updated, with consideration of all applicable and appropriate treatment modalities.
- d. All services and treatment are carefully structured to achieve optimum results in the most time efficient manner possible consistent with sound clinical practice.
- e. If treatment progress is not evident, then there is documentation of treatment plan adjustments to address such lack of progress.
- f. Care is rendered in a clinically appropriate manner and focused on the child/adolescent's behavioral and functional outcomes.
- g. An individualized discharge plan has been developed which includes specific realistic, objective and measurable discharge criteria and plans for appropriate follow-up care. A timeline for expected implementation and completion is in place but discharge criteria have not yet been met.

- h. Child/adolescent is actively participating in treatment to the extent possible consistent with his/her condition, or there are active efforts being made that can reasonably be expected to lead to the child/adolescent's engagement in treatment.
- i. Unless contraindicated, family, guardian, and/or custodian is actively involved in the treatment as required by the treatment plan, or there are active efforts being made and documented to involve them.
- j. When medically necessary, appropriate psychopharmacological intervention has been prescribed and/or evaluated.
- k. There is documented active discharge planning from the beginning of treatment.
- l. There is a documented active attempt at coordination of care with relevant outpatient providers when appropriate.

### 3.4 Discharge Criteria

The following two criteria must both be met:

- a. The child or adolescent can be safely treated at an alternative level of care.
- b. An individualized discharge plan with appropriate, realistic and timely follow-up care is in place.

In addition to a and b above, any one or more of criteria c through l must be met:

- 1. The child or adolescent's documented treatment plan goals and objectives have been substantially met or a safe, continuing care program can be arranged and deployed at an alternate level of care.
- 2. The child or adolescent no longer meets admission criteria, or meets criteria for a less or more intensive level of care.
- 3. The child or adolescent, or family member, guardian, or custodian are competent but non-participatory in treatment or in following the program rules and regulations. There is non-participation to such a degree that treatment at this level of care is rendered ineffective or unsafe, despite multiple, documented attempts to address non-participation issues.
- 4. Consent for treatment is withdrawn, and it is determined that the child or adolescent, parent, or guardian has the capacity to make an informed decision and does not meet criteria for an inpatient level of care.
- 5. The child or adolescent is not making progress toward treatment goals despite persistent efforts to engage him or her, and there is no reasonable expectation of progress at this level of care; nor is the level of care required to maintain the current level of function.

## 4.0 When the Procedure, Product, or Service Is Not Covered

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### 4.1 General Criteria

Procedures, products, and services related to this policy are not covered when

- a. the recipient does not meet the eligibility requirements listed in **Section 2.0**;
- b. the recipient does not meet the medical necessity criteria listed in **Section 3.0**;
- c. the procedure, product, or service unnecessarily duplicates another provider's procedure, product, or service; or
- d. the procedure, product, or service is experimental, investigational, or part of a clinical trial.

### 4.2 Specific Non-Covered Criteria

Medicaid and NCHC shall not cover PRTF services that are ordered by the court when medical necessity criteria are not met.

Medicaid and NCHC shall cover not cover PRTF when the primary issues are social or economic, such as placement issues.

### 4.3 NCHC Non-Covered Criteria

Except as otherwise provided for eligibility, fees, deductibles, copayments, and other cost sharing charges, health benefits coverage provided to children eligible under the Health Choice program shall be equivalent to coverage provided for dependents under the NC Medicaid Program except for the following:

- a. no services for long-term care;
- b. no non-emergency medical transportation;
- c. **no EPSDT**; and
- d. dental services shall be provided on a restricted basis.

### 4.4 Medicaid Non-Covered Criteria

No additional non-covered criteria

## 5.0 Requirements for and Limitations on Coverage

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### 5.1 Prior Approval

For Medicaid, the provider shall obtain prior approval before rendering PRTF services.

The provider shall obtain prior approval before rendering PRTF services for NCHC] recipients.

## 5.2 Prior Approval Requirements

The provider(s) shall submit to DMA's designee the following:

- a. the prior approval request;
- b. all health records and any other records that support the recipient has met the specific criteria in **Subsection 3.2** of this policy; and
- c. if the Medicaid recipient is under 21 years of age, information supporting that all EPSDT criteria are met and evidence-based literature supporting the request, if available.

## 5.3 Limitations or Requirements

### 5.3.1 Certification of Need

Federal regulations require a Certification of Need (CON) be completed on or prior to admission to a PRTF facility when the recipient is Medicaid or NCHC-eligible or Medicaid or NCHC is pending. The CON:

- a. Must be done concurrently with the Medicaid application, when the application is done during the stay. The independent utilization reviewer must be contacted immediately to begin the review process.
- b. Must be completed by an independent medical team, including a qualified physician.
- c. Cannot be retroactive.
- d. Must meet all federal requirements.
- e. Must certify that:
  1. Ambulatory care resources within the community are insufficient to meet the treatment needs of the recipient.
  2. The recipient requires services on an inpatient basis under the direction of a qualified physician.
  3. Services can reasonably be expected to improve the recipient condition or prevent regression.

The last dated signature on the CON form determines authorization for payment.

A copy of the CON must be maintained in the recipient's medical record.

### 5.3.2 Therapeutic Leave

Each Medicaid and NCHC eligible recipient who is occupying a psychiatric residential treatment facility bed for which the North Carolina Medicaid or NCHC Program is then paying reimbursement shall be entitled to take up to 45 (non-consecutive) days of therapeutic leave in any calendar year from any such bed without the facility in which the bed is located suffering any loss of reimbursement during the period of leave. Therapeutic leave is also limited to no more than 15 days within one calendar quarter (three months).

- a. The taking of such leave must be for therapeutic purposes only, and must be agreed upon by the recipient's treatment team. The necessity for such leave and the expectations involved in such leave shall be documented in the recipient's treatment/habilitation plan and the therapeutic justification for each instance of such leave entered into the recipient's record maintained at the Residential Facility's site.
- b. Therapeutic leave shall be defined as the absence of a recipient from the residential facility overnight, with the expectation of return, to participate in a medically acceptable therapeutic or rehabilitative facility as agreed upon by the treatment team and documented on the treatment/habilitation plan.
- c. Facilities must reserve a therapeutically absent recipient's bed for him, and are prohibited from deriving any Medicaid or NCHC revenue for that recipient other than the reimbursement for that bed during the period of absence. Facilities shall be reimbursed at their full current Medicaid or NCHC bed rate for a bed reserved due to therapeutic leave. Facilities shall not be reimbursed for therapeutic leave days taken which exceed the legal limit.
- d. No more than five consecutive days may be taken without the approval of the recipient's treatment team.
- e. Facilities must keep a cumulative record of therapeutic leave days taken by each recipient for reference and audit purposes. In addition, recipients on therapeutic leave must be noted as such on the facility's midnight census. Facilities shall bill Medicaid or NCHC for approved therapeutic leave days as regular residence days.
- f. The official record of therapeutic leave days taken for each recipient shall be maintained by the State or its agent.
- g. Therapeutic leave is not applicable in cases when the therapeutic leave is for the purpose of receiving inpatient services or any other Medicaid or NCHC covered service in the facility of current residence or in another facility. Therapeutic leave cannot be paid when Medicaid or NCHC is paying for any other 24-hour service.
- h. Medicaid and NCHC benefits do not include non-emergency medical transportation. Transportation from a facility to the site of therapeutic leave is not considered to be an emergency; therefore, ambulance service for this purpose shall not be reimbursed.

## **6.0 Providers Eligible to Bill for the Procedure, Product, or Service**

To be eligible to bill for procedures, products, and services related to this policy, providers shall

- a. meet Medicaid or NCHC qualifications for participation;
- b. be currently Medicaid - enrolled; and
- c. bill only for procedures, products, and services that are within the scope of their clinical practice, as defined by the appropriate licensing entity.

## 6.1 Provider Qualifications

PRTF programs:

- a. Must be under the direction of a board-eligible or certified child psychiatrist or general psychiatrist with experience in the treatment of children.
- b. The Joint Commission on Accreditation of Healthcare Organizations, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation must accredit the program as a residential treatment facility.
- c. Hospital licensure is required if the treatment is hospital based.

## 7.0 Additional Requirements

*Note: Refer to Subsection 2.2 regarding EPSDT Exception to Policy Limitations for Medicaid Recipients under 21 Years of Age.*

### 7.1 Compliance

Providers shall comply with all of the following: applicable agreements, federal, state and local laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) and record retention requirements.

### 7.2 North Carolina Health Choice Requirements

#### 7.2.1 Audits and Compliance Reviews

DMH/DD/SAS and DMA (DHHS team) jointly conduct annual audits of a sample of Health Choice-funded mental health, developmental disabilities, and substance abuse services. The purpose of the audits is to ensure that services are provided to Health Choice recipients in accordance with federal and state regulations and that the documentation and billing practices of directly enrolled providers demonstrate accuracy and integrity. It is a quality control process used to ensure that medical necessity has been determined and to monitor the quality of the documentation of services provided. Local Management Entities (LMEs) may also conduct compliance reviews and monitor provider organizations under the authority of DMA. Any deficiencies identified in an audit are forwarded to DMA's Program Integrity Section, with the following information:

- a. A report of findings that summarizes the issues identified, time period covered by the review, and type of sampling; and
- b. Copies of supporting documentation, showing the specific billing errors identified in the audit and including the recipient's name, Health Choice identification number, date(s) of service, procedure code(s), number of units billed in error, and reason for the error.

Refunds or requests for withholdings from future payments should be sent to:

Office of Controller  
DMA Accounts Receivable  
2022 Mail Service Center  
Raleigh, N.C. 27699-2022

### 7.3 Medicaid Requirements

Documentation of PRTF services must meet both the requirements of the accrediting body and Medicaid and NCHC guidelines.

For Medicaid and NCHC, utilization reviews, including initial and continuing stay authorizations, are performed by an independent utilization review contractor. The utilization review contractor notifies the fiscal agent of the number of approved certified days.

## 8.0 Policy Implementation/Revision Information

**Original Effective Date:** December 1, 2001

### Revision Information:

Date	Section Revised	Change
09/01/2005	Section 2.0	A special provision related to EPSDT was added.
12/01/2005	Section 2.3	The web address for DMA's EDPST policy instructions was added to this section.
01/01/2006	Section 3.1	The section was revised to clarify the criteria for admissions.
01/01/2006	Section 3.2	The section was revised to clarify the criteria for continuing treatment.
01/01/2006	Section 3.3	The section was revised to clarify the criteria for discharge.
05/01/2006	Attachment A	The level of care and initial and continuing authorization criteria for Level D services was deleted from the policy.
09/01/2006	Section 5.2	Requirements and limitations related to therapeutic leave were added to the policy, effective with CMS date of approval, 8/19/2004.
12/01/2006	Section 2.3	The special provision related to EPSDT was revised.
12/01/2006	Sections 3.0 and 4.0	A note regarding EPSDT was added to these sections.
05/01/2007	Sections 2 through 5	EPSDT information was revised to clarify exceptions to policy limitations for recipients under 21 years of age.
05/01/2007	Section 8.1	Added UB-04 as an accepted claims form.
07/01/2010	Throughout	Session Law 2009-451, Section 10.31(a) Transition of NC Health Choice Program administrative oversight from the State Health Plan to the Division of Medical Assistance (DMA) in the NC Department of Health and Human Services.
03/01/2012	Throughout	To be equivalent where applicable to NC DMA's Clinical Coverage Policy # 8D-1 under Session Law 2011-145, § 10.41.(b)
08/01/2012	Throughout	Technical changes to merge Medicaid and NCHC current coverage into one policy, but neither policy substantially changed.

## **Attachment A: Claims-Related Information**

Reimbursement requires compliance with all Medicaid or NCHC guidelines, including obtaining appropriate referrals for recipients enrolled in the Medicaid and NCHC managed care programs.

### **A. Claim Type**

Institutional (UB-04/837I transaction)

### **B. Diagnosis Codes**

Providers shall bill the ICD-9-CM diagnosis code(s) to the highest level of specificity that supports medical necessity.

### **C. Billing Code(s)**

Providers shall select the most specific billing code that accurately describes the service(s) provided.

Providers shall code service in form locator 42 with the revenue code (RCC) 911 billed as one unit per day. A recipient is permitted up to 45 (non-consecutive) days of therapeutic leave per calendar year from the facility without the facility losing reimbursement.

### **D. Modifiers**

Providers shall follow applicable modifier guidelines.

### **E. Billing Units**

The provider shall report the appropriate procedure code(s) used which determines the billing unit(s).

### **F. Place of Service**

Inpatient Hospital, Residential Treatment Facility

### **G. Co-payments**

Co-payment(s) may apply to covered services, procedures, prescription drugs and over-the-counter drugs.

For NCHC, co-payments vary by the specific service rendered. Refer to the Basic Medicaid and NC Health Choice Billing Guide at <http://www.ncdhhs.gov/dma/basicmed/>. Health Choice recipient Identification cards also list all applicable co-payment amounts by service type.

## H. Reimbursement

Providers shall bill their usual and customary charges.

For a schedule of rates, see: <http://www.ncdhhs.gov/dma/fee/>

For NCHC, providers must bill their usual and customary charges. After any applicable recipient co-payments, Health Choice reimbursement at 100% of the Medicaid rate is payment in full. Psychologists, addictionologists or other behavioral health practitioners may at times need to see a recipient who has been hospitalized under the care of an admitting psychiatrist. When it is necessary for the outpatient provider to see an inpatient to facilitate treatment or facilitate transition back to the outpatient setting, that provider may be reimbursed when prior authorization is obtained from DMA's Utilization Review vendor.