Abstract: Over the past six years, Holston United Methodist Home for Children in Greeneville, TN, has made a concerted effort to change its culture of care and philosophy of treatment. A restraint reduction effort began in 1998, and a Treatment Model Task Force was created in 1999 in order to move the agency from a strict behavior modification treatment modality to one that focused upon establishing healthy relationships between staff and youth. The results of these combined changes have been a 92% reduction in physical restraints, an 85% reduction in the use of seclusion, and a 93% reduction in client grievances between 1998 and 2003. Overall, the culture and philosophy of care is one that has moved from an orientation of “control” to one of “connecting.”

Background

Like many child care organizations, Holston United Methodist Home for Children began as an orphanage in 1895 in the town of Greeneville, Tennessee. Over the years, it has adapted to the changing needs of children and families and has become a multi-program agency with the following services:

- Residential Assessment and Treatment;
- Community Group Care;
- Independent Living;
- Day Treatment;
- Foster Care (Low Intensity, Therapeutic, Medically Fragile, Emergency);
- In-Home and Reunification Services;
- Adoption (Domestic, International, Special Needs); and,
- Child Day Care.

Last year, Holston Home operated on a $10 million budget and employed 200 full time staff in four sites.

This paper primarily will focus on the culture shift in the residential, group care, and day treatment programs of the agency. However, the shift has positively impacted all other agency programs and services.

Restraint Reduction Effort

More than a year prior to the agency establishing a Treatment Model Task Force, a decision was made to focus on reducing restraints. An initial change that was made to achieve this result was a move to a different de-escalation and restraint technique curriculum. Along with this change, the amount of initial training hours was increased.
from 6 hours to 18 hours, and more instructors were trained in order to meet the demands of this increase in training. Also, the agency required staff to attend a refresher training every six months instead of the previous requirement of once a year.

Along with a greater emphasis on training and the use of de-escalation techniques (which were not a focus of our prior training), the approach to behavior management planning changed, as well. Before this time, seclusion and restraint were written into behavior management plans as the final steps of intervention if problem behavior continued to escalate. The new approach to behavior management planning moved to using only positive interventions, rewards for appropriate behavior and removed any mention of restraint, while greatly reducing the use of seclusion, as well.

Another factor that aided the restraint reduction effort was the agency’s continuous quality improvement (CQI) process. Not only were the numbers of restraints tracked in the different program areas, but goals were set for a percentage reduction in each area and for the agency as a whole. As goals were reached, the agency was able to celebrate its success.

However, success did not come in the initial push for the reduction of restraints because of poor planning and other mistakes. When the restraint reduction effort was announced to staff, it was announced as a stoppage of the use of restraints. Although the staff had more training in using de-escalation techniques, the use of these techniques had not become a working part of the treatment culture. So, in essence, the staff had no other tools or techniques to use in the place of restraints. As a result, the culture became chaotic, as staff took a “hands off” approach and youth escalated their behavior in order to have staff respond in some way to establish safety and control. In response to this chaos, the use of restraints were re-instituted as a way to regain control, and the number of restraints increased for short time.

Another mistake that was made was the lack of anticipating and addressing staff resistance to not using restraints. The restraint reduction effort was a mandate from management, of which the direct care and supervisory staff had little input or buy-in. Other factors that impeded the initial progress, and actually caused the agency to regress in reducing restraints including having a cottage of younger latency age males (6-10 years old) with no specialized program to meet their developmental needs and having two program directors hired into the agency who were more control-oriented in their approach to treatment.

To rectify these issues, several things occurred. Training was given to supervisors on how to understand and address staff resistance to change, and more input was sought from direct care staff on restraint reduction strategies. The younger male population was placed in therapeutic foster homes, where their developmental and treatment needs could better be met, and the two program directors were replaced by staff promoted from within the agency who bought into the restraint reduction effort and who had less control-oriented approaches.

Table 1 shows the progress that has been made over six years in reducing not only restraints, but also the number of staff and youth injuries associated with restraints.
Table 1. Restraint data.

<table>
<thead>
<tr>
<th>Year</th>
<th>Restraints</th>
<th>Youth Injuries Requiring Medical Attention*</th>
<th>Staff Injuries Due to Physical Management^</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>1447</td>
<td>6</td>
<td>36 (71%)</td>
</tr>
<tr>
<td>1999</td>
<td>660</td>
<td>2</td>
<td>27 (66%)</td>
</tr>
<tr>
<td>2000</td>
<td>169</td>
<td>0</td>
<td>4 (27%)</td>
</tr>
<tr>
<td>2001</td>
<td>93</td>
<td>3</td>
<td>12 (34%)</td>
</tr>
<tr>
<td>2002</td>
<td>169</td>
<td>0</td>
<td>17 (49%)</td>
</tr>
<tr>
<td>2003</td>
<td>116</td>
<td>0</td>
<td>11 (31%)</td>
</tr>
</tbody>
</table>

*Notates injuries requiring profession medical attention, i.e., emergency room assessment/treatment.

^Staff injuries that were filed as Worker’s Compensation claims. ( %) = percent of all staff injuries filed as Worker’s Compensation claims.

(Although data was not kept in this manner during this timeframe, it is estimated that restraints dropped from 65 per 1000 patient days in 1998 to 4.2 per 1000 patient days in 2001.)

As a side note to the restraint reduction effort, the use of seclusion (defined as placing a youth alone in a room from which egress is denied) dropped at the agency, as well. Although the reduction of the use of seclusion was not a focus of this effort, it came as an added benefit. This reduction, like the restraint reduction, can be attributed to staff utilizing more de-escalation techniques and taking a more positive approach to intervening with youth who were exhibiting difficult acting-out behavior. Table 2 shows the drop in the use of seclusion over the past six years.
Table 2. Seclusion data.

<table>
<thead>
<tr>
<th>Year</th>
<th>Seclusions*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1998</td>
<td>2642</td>
</tr>
<tr>
<td>1999</td>
<td>2114</td>
</tr>
<tr>
<td>2000</td>
<td>1259</td>
</tr>
<tr>
<td>2001</td>
<td>940</td>
</tr>
<tr>
<td>2002</td>
<td>607</td>
</tr>
<tr>
<td>2003</td>
<td>386</td>
</tr>
</tbody>
</table>

*Staff requested seclusions only. (Youth may self-request at “time-out” in the seclusion room, which were not included in this data.)

[It should be noted that the agency stopped the use of seclusion in July 2004. More details are mentioned below.]

Treatment Model Change

As the restraint reduction effort was making progress after the first year, other changes were occurring within the agency that both supplemented and complimented what was needed to move the agency from a control oriented approach that was steeped in behavior modification to one that focused on direct care staff “connecting” with youth through establishing healthy relationships. In 1999, Holston Home began the process of changing it treatment philosophy and culture of care. What we thought could be accomplished within a year is still in progress five years later. We began with a core task force of staff, including direct care staff, unit supervisors, administrators, and the CEO, all who discussed the basics of the philosophy that we wanted to develop. Small groups from this core group went out to visit other agencies throughout the Eastern U.S. to observe and explore various models of treatment. After these visits and the examination of literature of even more treatment philosophies, we decided to develop our own model based upon a theme that kept rising to the surface in our discussions, namely, the transforming power of relationships.

The Relational Model of Care and treatment is based upon a combination of models, theories, and research which include, child development theory, attachment theory, parenting skills, Re-ed, and Larry Brendto et al.’s Circle of Courage.

Various work groups were formed to develop the model and address specific issues. These groups focused on the following topics:
Although the treatment model is not fully in place, various pieces of the model have been introduced as new programs have been added and existing programs have been revamped. Even though all the “nuts and bolts” of the model have not been totally implemented, there has been a change in culture at the agency based upon the process.

One change has been the greater use of staff relationships – namely, using mentoring, teaching moments, and giving youth choices within boundaries – in caring for children rather than depending solely on behavior modification techniques in a token economy. Other changes have included a continued reduction of restraints, the reduction and subsequent cessation of seclusion, a 90+% reduction in client grievances with the implementation of a mediation program, an added mentoring program, an added equestrian therapy program, increased staff training, and the addition of a Staff Development Coordinator and a Best Practices Department. The mediation and mentoring programs embody two significant changes that merit more description.

Mediation

As we moved to a more relationship-oriented model of care, the agency chose to adopt a mediation program for both staff and youth. This mediation program not only served the purpose of giving both staff and youth better communication skills when negotiating through problems, but it also helped to give a more personal way for the youth to voice grievances. Before this mediation process was implemented, youth would voice concerns or seek to get problems solved through a formal written grievance procedure. Now, staff are trained to use either informal mediation techniques or a formal mediation procedure when the youth voice problems or concerns. If the youth are not satisfied with the mediation process, they may proceed with the filing of a formal grievance. New staff are trained in the mediation process during their initial orientation and training period, and the youth are trained in the mediation process as a part of their Life Skills curriculum offered in the Day Treatment Program or in their programs of care.

Table 3 shows the number of grievances (311) the year before the mediation program was introduced (2000) and the numbers for last year (23). Even more important
than the 93% decrease in the number of grievances filed is the drop in the number of founded grievances (Human Rights violations as determined by the agency’s Human Rights Committee.)

Table 3. Grievances data.

<table>
<thead>
<tr>
<th>Year</th>
<th>Grievances</th>
<th>Founded*</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>311</td>
<td>20</td>
</tr>
<tr>
<td>2001</td>
<td>170</td>
<td>24</td>
</tr>
<tr>
<td>2002</td>
<td>58</td>
<td>8</td>
</tr>
<tr>
<td>2003</td>
<td>23</td>
<td>0</td>
</tr>
</tbody>
</table>

*Founded grievances based upon Human Rights violations, as determined by the agency’s Human Rights Committee.

Mentoring

A part of the relational approach to care is the assignment of mentors to each youth. The agency has developed a two-fold approach to mentoring. Each youth in residential care has been assigned to a mentor, who is one of the staff working in the youth’s program. When the youth’s primary mentor is not on-shift, a secondary mentor is assigned to check in with the youth. Mentors are to spend one-on-one time with the youth as often as possible and check in each day with the youth.

For youth who do not have any identified family resources, another staff mentor may be assigned to them. These mentors are usually administrative staff or other staff who do not work in the youths’ program. They schedule one-on-one time with the youth as often and possible, with the agency allowing up to two-hours of work time each week being allowed for such interaction. Additional off-work time may be spent with the youth, at the mentor’s discretion.

Continued Progress

In the past year the agency has continued to make progress in refining the structure and practices related to a relational approach to care. A shift in case management and counseling/therapy services occurred that focuses more on building relationships and skills in the family. The agency also stopped the use of seclusion and, in its place, developed a way to address acting out behavior through the use of natural, logical, and imposed consequence. These areas of progress are described in more detail below.
Child and Family Specialists

One of the most recent changes to the agency’s approach to providing services with a relational approach is the re-alignment of the duties of case management and counseling/therapy. These duties had been divided between case management staff and clinical staff. However, this added one more person for the youth and his/her family to interact with, and there were often communication glitches between the case managers and clinicians regarding the youth’s case.

In January of 2004, the agency began implementing a Child and Family Specialist model, similar to the old “social worker” model, in which one person provides both case management and counseling or therapy services to the youth and his/her family. As a result, more youth are having more contacts with their families, and more work is being done with families in their homes. Another positive aspect has been that caseloads have been reduced to a maximum of only eight cases per Specialist. There have been some drawbacks, however. The agency lost much of its clinical staff through resignation because they did not want to adopt the role of case manager along with their therapeutic duties. (It should be noted that licensed clinical staff are assigned to youth with acute mental health needs.)

Stopping the use of Seclusion

As stated above, the use of seclusion decreased over the years as the use of physical restraint decreased. However, the agency believed that seclusion was still being over-used and, furthermore, that its use was contrary to the relational approach to care and treatment. Too, data from the restraint review process showed that, in 2003, 80% of the restraints were associated with the indication that seclusion would be used. After establishing a new philosophy about the use of seclusion and examining its ties to restraints, the agency made the decision to stop the use of seclusion altogether.

In making plans for this transition away from seclusion, management staff met to articulate its philosophy on seclusion, plan training, consider alternatives to seclusion, and to plan implementation of a seclusion-free milieu.

Implementing Natural, Logical, and Imposed Consequences

One of the replacements to the use of seclusion was the use of “teaching moments” and the use of natural, logical, and imposed consequences as a way to help youth learn alternatives to acting out behavior. A protocol was developed and training was conducted with staff on how to address youth who were exhibiting acting out behavior in a way that addressed the goal of the behavior and that offered replacement behavior rather than merely punishing acting out behavior, as had been done in the past.

Along with this, a list of natural and logical consequences was developed to address the most common acting out behaviors so that youth would be held responsible for their actions if they chose not to use adaptive replacement behavior. If such behavior persisted, imposed consequences, in the form of “grounding” youth from privileges, were developed in order to make the youth uncomfortable with the consequences of their continued behavior.
One unique aspect that was added to this, though, was the final step in helping the youth to deal with the negative consequences of acting out behavior, which was helping them make amends for their behavior. The process of making amends not only helps to give control back to the youth, but it also teaches them to repair and restore relationships that may suffer due to their behavior.

Organizational Change

The ideas of Edgar Schein (1992) have been helpful to the agency in understanding the process of organizational change and in implementing further changes. Schein wrote that staff resistance is normal and to be expected. In response to this, the agency developed a training for supervisors on how to recognize and address resistance to change within the staff.

One unique outlook that Schein has on the dynamics of staff resistance is summed up in what he calls the “20-50-30” rule. He explained that, when implementing change, an organization can expect 20% of its employees to support the change and be willing to be change agents while 30% of the employees will be resistant to change. However, he says that the 50% in the middle have no strong feelings on either side and are in need of direction on how to implement the changes and do their jobs in a new way. (Schein admits that this formula is based on his years of experience rather than on any hard research.) He advises that organization should concentrate their change efforts on the 50% who only need direction rather than in trying so hard to convert the 30% who are resistant to the change. With attention to the 50%, when change is implemented, 70% of the employees are ready to implement changes when called to do so.

Schein also points out that the organization must bring about change by creating a new culture. This new culture is established by creating common goals, common language, and common procedures for solving problems. A three-step process for establishing this new culture includes “unfreezing,” “cognitive restructuring,” and “refreezing.” By “unfreezing” the employees are given disconfirming information about what is not right with the current culture and practices. Furthermore, anxiety or guilt is created for continuing the culture and its practices, and then creating an environment of psychological safety is necessary to allow people to react the need to change and the anxiety that it creates for them. The second step, cognitive restructuring, can be summed up in create new ways of thinking about the culture and how that philosophy should be practiced. Finally, “refreezing” occurs by establishing facts about how the new culture and practices are beneficial for all those involved. Too, this “refreezing” is established by offering rewards to those who comply with the culture and sanctions to those who do not.

It must be remembered, however, that changing an organizational culture takes a great deal of time and effort. Schein estimates that it can take 5 – 15 years to fully change a culture, and he points out that a time of disequilibrium should be anticipated as the transition to a new culture takes place.
Mistakes and Successes

In going through this change of culture, the agency has made mistakes in the process. For instance, inconsistency in task force attendance often caused us to revisit issues that had been addressed in earlier meetings and work groups. Too, we often wanted to come to consensus on issues where there were diametrically opposing opinions expressed, which took a great deal of time and energy, rather than making a decision based on majority vote or administrative necessities in a timely manner. Other dynamics, such as agency reorganization due to funding issues and spending a great deal of time preparing for re-accreditation, caused the process to be more protracted than it could have been. As a result, the effort has lost energy and focus over the last two years.

Overall, however, the way that the youth are cared for and treated has been changed in positive ways. There is a more therapeutic and less punitive feel to the therapeutic milieu. There is more attention to their development needs and more effort put toward teaching them new adaptive behaviors rather than punishing them through point and level losses (and restraints and seclusions) for their maladaptive behaviors. Generally, the youth believe that the staff genuinely care for them and are not here just to keep them “locked up.”

It has created a different climate for staff, who are required to take a more sophisticated and nurturing approach in dealing with the youth and their behaviors rather than doling out overly simplistic, punitive consequences. As a result, more training and supervision is required to support staff in this new approach. In essence, there is a parallel process in building relationships and skill with staff, which is necessary for this culture of care to be effective with youth. Overall, the staff believe that they are making a difference in the lives of the youth through their work at the agency. When asked about this on the latest annual staff survey, 93% of the direct care, case management, and clinical staff answered that they agreed or strongly agreed that they made a difference through their roles in the agency.

The model we are working toward is still under development, and there is room for improvement as we seek to better articulate and implement this relational approach of care and treatment. However, the process that we undertook to change our culture of care and the time and attention that we gave to define our philosophy and delivery of care to youth and families has radically changed the agency for the better and has improved the quality of care for our youth. Moving from “restraints” to “relationships” illustrates the shift in philosophy inherent in this change.
Bibliography

Holston Home’s Restraint Reduction Process


Organizational Culture