

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

INTRODUCTION:

This chapter offers a vision and a framework to support the efforts of administrators, program directors and supervisors to empower direct care workers who work with children and youth (*children*) in institutional care. There is increasing recognition that many children have “serious emotional disturbance “ (SED) as well as exposure to severe, chronic trauma, even though many of these children have not been identified as such (NASMHPD and NTAC, 2004). The ultimate goal is for direct care workers to maximize their effectiveness with children in their care, so that the children can address the challenges that led to their admission and successfully return to the community. Typically, this involves addressing the child’s mental health needs, promoting skill building and prosocial conduct, and working with the child’s family and community based resources. While applicable to all staff in contact with children including therapists, educators, psychologists, and child psychiatrists, the ideas presented here are especially important for direct care workers, given their central role with children in institutional care, whether in Mental Health, Child Protection, or Juvenile Justice. The ideas are also applicable to direct care workers in Special Education, in-home services, and community services.

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

THE CONTEXT THAT SHAPES DIRECT CARE STAFF FUNCTIONING:

While we begin with the recognition that a program cannot help children without effectively trained and guided direct care workers, there are other important prerequisites for an effective program that meets of the needs of its identified population of children. Some of these parameters are identified below:

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

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

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

Direct care workers need to understand that relationship building with children with SED, prior traumatic experiences, multiple losses, drug and alcohol problems, and/or disturbing behavior is far from easy. Guardedness is typical and may actually be protective for the child. Relationship building requires time, patience, use of relevant individualized information, and a

readiness to follow the lead of the child. An ability to listen and withhold judgment is indispensable. The relationship needs to be person-to-person, not just worker-to-client. This means that the direct care worker relates to the child first as a human being, and only then as someone with identified problems or challenges. Genuine caring is essential, since the child can readily surmise when a staff person is feigning interest and “going through the motions.” A respectful relationship is collaborative rather than primarily hierarchical in nature. A child learns respect not through lectures but through repeated experiences of being respected. In some manner, verbal or otherwise, the direct care worker conveys the idea that “we need to work together to understand what is going on and how to help you out – I don’t have all the answers myself.”

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

FROM SOUP TO NUTS – INTRODUCING AND MAINTAINING THE VISION:

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

1. The agency Mission and Philosophy statements.
2. The initial job interview with the direct care applicant.
3. The initial staff orientation, encompassing both overall program operations and specific approaches to prevention, de-escalation, and safe crisis management
4. Ongoing staff training throughout the calendar year.
5. Regular staff supervision and mentoring.
6. Periodic performance evaluations.

7. Ongoing linking of relationship building with children to the data system and the Quality Improvement process.

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

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

VALUES AND BELIEFS:

The first key domain, which can either empower or handicap direct care workers, involves their values and beliefs. In general, values and beliefs organize our perceptions of children and their families, and therefore greatly influence our subsequent interactions and interventions with them. While a person is free in their private life to maintain any values and beliefs they choose, the direct care worker’s role involves being “therapeutic,” and therefore their values and beliefs need to be therapeutically based. Fortunately, considerable consensus has been achieved as a result of the national system of care movement and the formulation of CASSP (Child and Adolescent Service System Program) Principles, both based on groundbreaking work in the 1980’s at the National Institute of Mental Health in Washington D.C.

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

1. child-centered (organized around the actual strengths and needs of the child, and individualized in nature),
2. family-focused (recognizing the central role of parents and the family in raising children, and building upon family participation and leadership for both a specific child and in overall policy development),

3. community-based (supporting the child's remaining in the home and community, whenever possible, or returning to the community as soon as possible when in placement, and using services and resources convenient to the family, within the community),
4. multi-system (collaborative efforts at meeting the child's needs by all involved child-serving system representatives and stakeholders),
5. culturally competent (recognizing the unique cultural characteristics of each child and family, and ensuring that services support and build upon this culture),
6. least restrictive/least intrusive services and interventions (ensuring that services effectively address the needs of the child without involving unnecessary restriction of movement or intrusion into child and family living).

Consistent with CASSP Principles and related concepts such as “strengths based treatment” – which involves an ongoing commitment to identify the multiple strengths of the child, family, community and service system, and to build upon them while providing services – there are certain values and beliefs on the part of direct care staff that may predispose toward therapeutic relationships. These relate to the worker's view of children, families, the nature of treatment, and their personal motivation to serve as a direct care worker.

1. Values and Beliefs About Children:

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

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

- a. Significantly different than adults, due in part to an extensive, rapid developmental process, which staff need to recognize and promote.
- b. Doing the best they can, given current circumstances and limitations (involving limitations of knowledge, skills, stability, and support).
- d. Survivors, whose behaviors often reflect life-preserving adaptation to difficult circumstances, a lack of skills, and/or physiological imbalances. Children therefore constitute more than their behaviors, and should not to be viewed as “bad,” “manipulative,” “attention seeking,” etc.
- e. In need of understanding, respect, support, and redirection – not control, coercion, or shaming.
- f. In need of encouragement to recognize and build on their strengths and competencies.
- g. Having a capacity for resilience and positive change, in conjunction with appropriate treatment and support.

2. Values and Beliefs About Families:

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

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

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

3. Values and Beliefs About the Nature of Treatment:

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

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

- a. Viable and meaningful.
- b. Mediated through relationships and restoration of hope.
- c. Facilitated by a team process in which team members collaborate together.
- d. Focused on accountability and not on punishment of the child.
- e. Needing to avoid violence, threats, and coercion towards children.
- f. Needing to keep hands off children and avoid use of restraint, except in an extreme emergency as a last resort to maintain safety.
- g. Needing to help child and family identify and pursue constructive choices.

4. Values and Beliefs Underlying Personal Motivation:

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

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

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

JOB-SPECIFIC EXPECTATIONS AND COMPETENCIES:

The second key domain to empowering direct care staff involves identifying and promoting job-specific expectations and related competencies. Frequently, job-specific expectations and competencies are based on justified concepts of “professionalism” on the job. Such expectations include but are not limited to: timeliness and reliability, honesty, personal appearance, alertness and judgment, and the maintenance of respectful, non-abusive relationships. We agree that these and similar expectations are fundamentally sound and necessary. In addition, however, three other elements are also important – competency in relationship building and the therapeutic use of these relationships; effective communication with families and outside professionals; and internal communication skills, as reflected in written documentation and verbal information sharing. Since the latter 2 elements (skills in external and internal communication) are reasonably evident, we focus below on skills related to relationship building and the therapeutic use of these relationships.

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

Once formed, a therapeutic relationship should be used to help the child implement the individualized treatment plan and to promote the child’s coping and adaptation. On a routine basis and in the absence of a particular crisis or concern, this involves the direct care worker’s being regularly available to the child, offering input, support, and feedback as appropriate. Efforts to be strengths based and to proactively anticipate the needs of the child constitute the essence of primary prevention, which aims to promote the child’s overall wellbeing and avoid crisis.

When a crisis does occur or appears imminent, the direct care worker offers quick intervention in order to address the problem early and prevent further escalation. Sometimes, supportive statements and low-key redirection suffice and the situation can be resolved uneventfully. At other times, however, the direct care worker needs to intervene more

intensively by using a variety of de-escalation approaches, with the goal of defusing the situation, avoiding need for restrictive physical procedures such as physical restraint, and restoring safety and calm. Efforts to address and resolve crisis in the least restrictive and intrusive manner are part of what is known as secondary prevention. All effective primary and secondary prevention efforts build upon pre-existing relationships between the direct care worker and the child.

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

Given the importance of de-escalation as a skill set to soothe and settle a distressed child and as a tool to avoid the need for physical restraint, it is important that direct care workers have extensive training in a range of de-escalation approaches and interventions. Staff untrained in relationship building and in de-escalation may conclude that they possess few if any alternatives other than physical force, when a child is out of control. In addition, de-escalation cannot be implemented solely as a “technique” in the absence of a caring relationship and a strong commitment on the part of involved staff to guide the process to a non-violent resolution.

Below are some useful approaches to de-escalation. While not inclusive, the list can serve as a catalyst to administrators, program directors, supervisors, and direct care workers themselves:

1. Listening.
2. Remaining calm and non-judgmental.
3. Offering support and concern.
4. Soothing child through voice and manner.
5. Having a non-stressful “conversation” with the child.
6. Acknowledging legitimacy of some aspect of concern or grievance.
7. Highlighting current evidence of coping, despite distress.
8. Avoiding shaming and humiliation.
9. Using previously obtained information and previously completed tools.
10. Asking questions.
11. Expanding the knowledge base about the child.
12. Reminding the child of his/her own identified goals.
13. Highlighting other strengths and accomplishments of child.
14. Asking directly, “How can I help?”
15. Asking child for help (“Help me to help you”).
16. Providing space, and time, as indicated.

17. Judicious use of humor (always avoiding sarcasm and put-downs).
18. Redirection, ensuring the child opportunity to save face.
19. Openness of staff person to input from other staff, as indicated.
20. Other.

PROFESSIONAL SELF-AWARENESS & SELF-CONTROL:

The third key domain to empowering direct care staff involves assessing and promoting professional self-awareness and self-control. This constitutes an area infrequently targeted in training, supervision, and especially performance evaluations. Direct care staff soon enough learn that intensive contact with troubled, challenging children can be highly stressful. It is preferable that staff be oriented to this dynamic from the outset. They also need to understand that, no matter how professional and “objective” they may try to be, the actions and behavior of some children will nevertheless provoke negative personal reactions – anger, anxiety, hurt, and other emotions that should not be expressed or acted upon. In the absence of self-awareness and the capacity for self-control, the direct care worker may engage in counter-aggression toward the child, destabilizing both the child and the milieu. In fact, there is increasing awareness that counter-aggression and over-control by staff underlie many episodes of physical restraint (NETI 2003, Hughes 2002).

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

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

I. CONCLUSION – A TIME OF OPPORTUNITY:

Now is a time of opportunity to improve the treatment and interventions offered to children with challenging problems, whether it involves SED, drug and alcohol use, antisocial and disturbing behaviors, the consequences of neglect, abuse or other trauma, or a combination of these. There is an increasing emergence of evidence-based interventions, and a consensus has emerged that programs need to collect data related to both individual and aggregate outcomes (President’s New Freedom Commission on Mental Health 2003). A new field known as trauma-

informed care has emerged (NETI 2003), highlighting the pervasiveness of trauma in the lives of children and reinforcing our recognition that effective interventions are, first and foremost, relationship-based. Relationships need to support prevention and competence at multiple levels. Staff working with children need to recognize that use of coercion and restrictive procedures are counter-therapeutic and reflective of treatment failure (Hodas 2004a). Instead of promoting stability and safety, physical interventions create instability and traumatize and/or re-traumatize children (NETI 2003).

Children are stigmatized and inappropriately labeled in our society not just for “mental illness” but also for disruptive and antisocial behavior, without regard to the underlying basis of such behavior. Too often, it is assumed that the child in question is nothing more than the sum of his/her behaviors, even though these behaviors may only reflect a small part of that individual’s totality and may be grounded in significant prior life experiences.

Three domains – values and beliefs, professionalism including competencies related to relationship building, and self-awareness and self-control – represent points of departure for programs committed to enhancing the competence, morale, and sense of mission of its direct care staff. With the appropriate training, supervision and mentoring, and with a similarly directed performance evaluation process, direct care workers can be assisted in maintaining therapeutic values and beliefs and therapeutically based skills sets that foster therapeutic relationships and promote the wellbeing and resilience of children. By being aware of personal reactions to stressful interactions and events in the workplace, the direct care worker gains the self-knowledge that can lead to self-control and the continued capacity to respond therapeutically.

Direct care staff often bring desire and energy to the table. What they need is training, supervision, and mentoring. Only when the needs of direct care staff are met can they, in turn, consistently address the needs of children. The most effective method for helping children remains therapeutic relationships. The message being conveyed to the child should be one of “salvation and forgiveness” (Canada, 1998), along with reassurance that change is possible, once the child makes the commitment and is prepared to accept help from those willing to share the road and point the way.

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