

JKM TRAINING, INC. NEWSLETTER

Safe Crisis Management Training Programs

Fall 2009

MESSAGE FROM THE PRESIDENT

Welcome to another Newsletter. In this very late edition you will find some narrative of interest, some very important training announcements and (hopefully) some helpful training tips. We apologize for the publishing delay of this edition and are hopeful you will find the content to have merit.

Currently, we are all trying to navigate our way through the difficult tides of the economy. Budgets have been cut and staff positions and resources reduced. Trainers across the field are facing the task of meeting mandates with less support and fewer resources. We encourage all trainers to press for fidelity to the SCM model and to be sure to document any imposed changes cutbacks may cause in their training routine. We extend to you our best wishes for training success.

Best Regards,
Joseph Mullen
President

The Use of Restraint and Seclusion in Public Schools Has Become a National Debate

Exposure of the widespread abusive use of restraint and seclusion in public schools has sparked Congressional hearings eventually leading to federal legislation or standards focused on this issue. During the month of May, several advocacy groups provided Congressional staff with substantial information and policy recommendations from which legislation or standards will be crafted. Representative, George Miller (D), of California is the leading Congressman on the initiative and Secretary of Education, Arne Duncan, have vowed to bring federal focus to the issue during this calendar year.

Schools and organizations using the Safe Crisis Management training model can rest easy regarding the outcomes of this initiative as our curriculum is consistent with all of the reform positions that have been offered. While SCM does not cover the use of seclusion specifically, it sets the threshold for use on the same line as restraint. SCM has defined this threshold as circumstances in which "Harm to Self or Others" is present. The advocacy group on the front end of this initiative is the Council for Children with Behavior Disorders (www.ccbd.net), which is a Division of the Council for Exceptional Children (CEC). Their position paper, which has recently been officially adopted by the CEC reads like a draft of the SCM curriculum. Especially clear is their insistence for the use of "positive behavior support", "functional assessment", "behavior support planning" and "debriefing". Furthermore, they reinforce our long standing "least restrictive" intervention approach, while clearly recognizing some emergency situations will occur where restraint and seclusion may be needed.

In addition, and perhaps of most interest to SCM trainers, the reforms call for the training of teachers in crisis intervention strategies and techniques. Of course, training costs money so it is likely that some federal "stimulus funds" will be directed to this area.

JKM Training, Inc. was contacted by Congressional Committee staff regarding research on restraint as well as several other issues. In those discussions, we made clear that researching only the negative outcomes results in a very narrow perspective. It was indicated an accurate picture could only be achieved when the thousands of positive interventions which occur each day in schools and organizations were also counted. We were also clear in asserting the large majority of negative interventions, which are highlighted in the advocacy reports, occurred in situations where staff training was inadequate, administrative oversight was negligent and antiquated values and beliefs surrounding student discipline still flourished. Readers are advised to remain alert to the changes that are proposed and judge just how closely they reflect the SCM curriculum.

Training News Highlights

KidsPeace training in Maine:

Senior trainer, Charley Cheek, delivered an SCM Instructor's Certification program to KidsPeace staff at their Ellsworth facility in Maine in early May. The program was attended by KidsPeace staff from Maine and Georgia. Participants were exceptionally appreciative of Charley's effort.

Los Angeles and California Department of Juvenile Justice:

Senior trainer, Dr. Steve Laidacker, spent significant time with the Los Angeles County Probation and Detention staff in April. The Department of Probation and Detention, under the leadership of Mr. Ron Barrett, continues to work diligently on SCM training. They completed both a SCM Instructor's Certification and Recertification training.

Dr. Laidacker also provided staff refresher training to the California State Department of Juvenile Justice trainers. Barry Gold who has been the Coordinator of our SCM training for DJJ has retired and been replaced by Lt. Brenda Jensen. We are grateful to Barry for his wonderful assistance and look forward to working with Lt. Jensen.

Georgia Department of Juvenile Justice:

A system-wide reform in Georgia found Steve teaming with Senior trainer, Jerome Flint, to initiate a SCM Training program for the Georgia Department of Juvenile Justice. Jerome has delivered three SCM Certification training in Georgia, while Steve has provided policy consultation and training for administrators. This initiative has seen very active support from DJJ Commissioner, Albert Murray, and exceptional coordination by Training Director, Fabienne Tate.

Washington D.C. Department of Youth Rehabilitation Services:

Jerome Flint delivered a SCM Certification training for the Department of Youth Rehabilitation Services in May, which was followed by a series of staff training programs that Jerome mentored. Gillian Meyers, Training Director for DYRS, was exceptionally helpful in the coordination of this program.

Maryland Approves SCM Curriculum:

The Maryland Governor's Office for Children conducted a review of various behavior management and crisis intervention training models during 2008. SCM was one of the few models approved to provide behavior management and crisis intervention training for residential child programs in the state of Maryland. Subsequently, Dr. Steve Laidacker and Jerome Flint conducted the first public SCM Certification trainings in Bowie and Towson, MD.

Additional On-site Training

Abraxas, Canon City, CO; Abraxas, San Antonio, TX; Abraxas I, Marienville, PA; Abraxas LDP, South Mountain, PA; Adelphoi Village, Latrobe, PA; Alternative Learning Center, Plains, PA; Beacon Light Behavior Health, Bradford, PA; Bernalillo County Juvenile Detention, Albuquerque, NM; Big East Cooperative - KEDC, Ashland, PA; Central Kentucky Special Education Cooperative, Lexington, KY; Charleston County School District, Charleston, SC; Clay County Schools, Green Cove Springs, FL; Connecticut CSSD Training Academy; New Britain, CT; Connecticut Juvenile Training School, Middletown, CT; CPC Behavioral Healthcare, Morganville, NJ; Department of Human Services, Philadelphia, PA; Department of Public Welfare, Harrisburg, PA; Derry Township Schools, Hershey, PA; Edmund L Thomas Adolescent Center, Erie, PA; George Junior Republic, Grove City, PA; Green River Regional Educational Cooperative, Bowling Green, KY; Halswell Residential College, Christchurch, New Zealand; Intermountain Centers for Human Development, Tucson, AZ; Kibble Education and Care Centre, Paisley, Scotland; Lake Mary Center, Paola, KS; Luthern Social Services, Sioux Falls, SD; Miami-Dade County Public Schools, Miami, FL; Montrose Area School District, Montrose, PA; New Jersey Juvenile Justice Commission, Sea Grit, NJ; NHS Human Services, Lafayette Hill, PA; North Schuylkill School District, Ashland, PA; Oldham County Schools, Buckner, KY; Punxsutawney Area School District, Punxsutawney, PA; Ridley School District, Folsom, PA; Sara Reed Children's Home, Erie, PA; Schuylkill Intermediate Unit #29, Mar Lin, PA; Seattle Children's Home, Seattle, WA; Shiloh Treatment Center, Manvel, TX; State of New Mexico CYF, Albuquerque, NM; Tennessee Corrections Academy, Tullahoma, TN; Wilderness Trail Special Education Cooperative, Richmond, KY; and the Wyoming Valley West School District, Kingston, PA

Thoughts on the Therapeutic Value of Emergency Safety Intervention (Restraint)

Several years ago a debate occurred in the professional community regarding the therapeutic value of emergency safety intervention. Those claiming restraints were therapeutic perceived the acting-out behavior as an emotional purging, and when handled properly, led to a rare opportunity for "therapeutic progress", or positive growth and development. Those who believed restraint to be a "therapeutic failure" claimed the intervention damaged relationships and traumatized individuals. While the reality of this claim could be demonstrated by specific reports, it was also true the accusation was a calculated spin used to advance the cause of restraint elimination in the field. Their belief was any behavior prompting emergency safety intervention was due to the failure of therapeutic efforts on the part of the program or the staff. Their premise was a therapeutic environment could be created and sustained, which would support individuals comprehensively and eliminate behavior that prompted restraint. In addition, they suggested emergency safety intervention was largely a function of a staff culture in which aversive intervention was used to accomplish behavior compliance.

The emotional overtones of this debate were at times excessive. Anyone who carried the banner of restraint elimination was viewed by their opposition as denying the reality of individual behavior. Anyone who supported the merits of emergency safety intervention was quickly categorized by advocates as aligned with the culture of aversion. As a result, many who recognized the positive function of appropriate emergency safety intervention chose to be silent in the debate. Over time, the emotional tone of the argument diminished and the silence began to break.

In the Safe Crisis Management curriculum we used the label, "emergency safety intervention" to describe the use of restraint hoping it would bring balance to the argument. Titling restraint as an "emergency" strategy allowed restraint critics and oversight authorities to find legitimate function for such intervention. The emergency function of restraint could be understood as separate from the cadre of prevention and de-escalation intervention strategies that were deemed "therapeutic." This separation allowed restraint critics to keep the premise of their argument intact, while providing legitimacy to restraint interventions that could not be avoided.

The field now recognizes some emergency safety intervention is necessary. However, the perception that restraint cannot be therapeutic still prevails. We believe it is time to once again raise issue with the restraint critics' position on the therapeutic character of appropriate emergency safety intervention. It is our conclusion that emergency safety intervention can be a therapeutic activity. This is based on an assumption that treatment is a therapeutic process composed of a variety of activities. Any single intervention activity can be therapeutic provided it is consistent with treatment goals and not harmful. We believe the success or failure of an intervention is a matter of rationale, judgment, correct implementation and individual readiness. Thus, we believe restraint has as much therapeutic potential as any strategic activity used by staff.

Assuming that behavior is "harmful to self or others" constitutes an emergency situation, does it not follow that the action used to alleviate the danger is therapeutic? Is this not the equivalent of a bandage applied to a bleeding wound? Is the "bandaging" not a therapeutic activity?

We believe bandaging a wound is clearly a therapeutic activity. The bandage is applied to stop the "harmful" bleeding; however, it must be done correctly. The bandage must be the right size for the wound, wrapped and secured with the right amount of pressure. It should have "antiseptic" and "sterile" composition. Of course, it must be removed appropriately and at the right time. A bandage that is too tight can cause harm, as can a bandage that is unclean or left in place too long. What makes a bandage therapeutic and what makes emergency safety intervention therapeutic is much the same. It requires legitimate need, rational intention, correct implementation and positive outcome.

We can become more specific in our argument to validate the therapeutic potential of emergency safety intervention by looking at...

Who? There must be a legitimate service relationship between the provider and the receiver.

What? The strategy must be a recognized/validated activity with helpful purpose and deliberate steps/components that have been reviewed regarding safety.

When? The strategy must be timely - needed at the moment but temporary with limited duration.

Where? The strategy must be delivered in a locale that supports its use.

Why? The strategy must be intended for positive outcome to relieve a "harm to self or others" situation and after less intrusive strategies have been exhausted.

How? The strategy must be delivered with an accepted level of professional correctness as determined by formal training prior to implementation.

When a professionally recognized emergency safety technique is used correctly in order to protect from harm with a positive outcome intended, do we not meet the criteria for a therapeutic activity?

The criteria below are offered to determine our therapeutic impact or lack thereof:

First: If harm is avoided and conflict resolution/positive problem-solving is the outcome, then the activity is a successful therapeutic effort.

Second: If harm is not avoided because of accident but positive intention and correct application was attempted, the activity can be judged as unsuccessful with accidental outcome. This can be said of any botched counseling session, therapeutic recreation activity, etc. The counselor who attempts to model appropriate dress by wearing a clean yellow shirt, but was unaware that the color yellow triggered traumatic flash back, creates a harmful situation by accident.

Third: If harm occurs by well intended but incorrect application, then the activity can be judged to be negligent because of incompetence. The teacher who conducts a museum trip and returns to school minus one student because she did not count heads creates harm by incompetence.

Fourth: If harm is a function of deliberate intent, then a therapeutic outcome does not exist and the activity can be judged as abusive. If the teacher publicly belittles a slow learner, the harm is abusive.

For the therapeutic aspect of emergency safety intervention to be maximized, it must be coupled with the subsequent activity of debriefing that is focused on the individual's behavior motives and choices and the service providers actions in relation to those motives and choices. For many individuals, behavior that results in emergency safety intervention contains an emotional and physical crescendo, one outcome of which, is a sense of exhaustion. In the exhausted state, individuals are often open to discussion that otherwise would generate defense mechanisms. There is, for those capable of using these empowered moments, an opportunity for emotional growth and development. These are moments for accelerated maturation in which superficial, as well as, core development issues can be impacted. Reflection on personal behavior motives and choices can produce understanding, as well as, options that will serve well for the future. Those individuals who lack capacity for such interaction can be coached to the level of his/her ability. In all situations, this outcome strategy should provide valuable content to be added to new or existing Behavior Support Plans. In addition, these are opportunities for staff to gain insight regarding the individual's view of staff's interventions. Ideally, staff can discover how their interventions affect individuals. This information can provide staff with direction for future interventions. Continuing to believe emergency safety interventions can never be therapeutic denies that protecting someone from "harm to self or others" behavior is a positive activity.

Verbal de-escalation strategies sometimes protect individuals from "harm to self or others" behavior. They are recognized as positive activities when they assist the individual to stay in or to regain the personal control they are losing. Emergency safety interventions are used only when the individual has crossed the line and is engaging in harmful behavior. When these strategies prevent a harmful outcome, they must be seen as positive.

Tips for Trainers

Using Videos in Training:

The use of videos in training can be a tremendous reinforcer. The adage that "a picture is worth a thousand words" significantly expands if those pictures are moving and talking. Videos can be used to reinforce a topic, to introduce a topic, to inspire, to add meaning or to culminate a topic or day. The use of this modality should not be expected to carry the training. It is a supplement which takes skill to utilize effectively.

The first area of concern is the introduction. Charley, Jerome and I have all seen situations where a trainer has said, "Okay, now we are going to watch a video". With this type of introduction several potential conclusions can be drawn:

1. The instructor does not know how to introduce a video.
2. The instructor is using the video to fill time.
3. The instructor has not previewed the video.
4. The video may or may not be applicable to the current topic.

Introducing a video has to be done in a manner that will contribute to the transfer of learning.

There should be a specific reason (or reasons) for the video and its connection to the curriculum should be verbalized. The video should not last more than about 20 minutes (longer videos tend to lose their effectiveness). The next phase of the introduction is to provide the trainees an assignment. Some examples may include:

1. Specific items to identify.
2. Examination of attitude or conviction.
3. Standards followed or ignored.
4. Attempts which succeeded.
5. Attempts which caused more difficulty.
6. Characters and their roles or flaws.