association of
CHILDREN'S
RESIDENTIAL CENTERS

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Redefining Residential:
Creating Non-Coercive Environments
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This is the tenth in a series of papers issued by the Association of Children's Residential Centers (ACRC) regarding key issues faced by the field in response to emerging research, policy, and best practice. ACRC is the longest-standing national association focused exclusively on the needs of children who access residential treatment, and their families.

This paper builds on the previous papers in the Redefining Residential Series to address creating non-coercive environments in residential treatment. The importance of establishing such environments in residential milieu settings has been a focus of attention for policy makers for almost two decades. Initially ensconced in issues related to child safety, client rights, and the reduction/elimination of restraint and seclusion, the rapidly emerging epidemiological and neurobiological research increasingly points to the deleterious effect of overt and subtle coercion alike on individuals, especially children, suffering from the impacts of adverse childhood experiences, toxic stress, and trauma. Creating non-coercive environments not only helps avert recapitulation and re-enactment of traumatic experiences, but also actively promotes interpersonal and cognitive skill development, and positive outcomes.

This paper is derived from ACRC's national conferences in 2012 and previous years, and from extensive work occurring in the neurobiological and epidemiological arenas. It will define coercion in the context of neurobiological research, address issues related to restraint and seclusion in residential treatment, identify organizational factors that can amplify or diminish coercive factors, and discuss system issues.

The Neurobiological Impact of Coercion
The extensive and growing body of research in the interpersonal neurosciences has generated the now common knowledge in the field that adverse childhood experiences impede neuro-cognitive development. Simply put, chemicals that are released in the brain in response to stress interfere with the development of healthy neuro-connections that optimize cognitive and emotional functioning. When children experience stress and trauma in childhood, the neural stress response pathways become increasingly strengthened, at the expense of the brain's development of healthy, adaptive strategies that facilitate effective coping, relationships, and behavioral control. As one researcher succinctly puts it: "What gets activated gets learned." These children essentially become hard-wired to stress and reactive to even what appear to be innocuous stimuli, rather than being capable of regulating their emotions and behavior, and the flight/ fight/ freeze response basically becomes automatic.

This of course describes the typical child referred to residential treatment, who enters care with significant limitations in the ability to use thought to mediate experience, relying non-consciously on the hard-wired automatic responses to stimuli. Thus a fundamental task of treatment is to facilitate the development of neuro-connections and cortical skills that will enable youth to better respond to their experience and function more effectively. There are several cognitive-based treatment and assessment models being utilized in residential and hospital settings around the country, including Trauma-Focused CBT , Collaborative Problem Solving (CPS), Trauma Systems Therapy, Dialectical Behavioral Therapy (DBT), Mentalization-Based Treatment, Neurosequential Model of Therapeutics, and others. But what is equally

or more critical in residential settings is to establish environments that are experienced as supportive and interpersonally healthy and that do not, in effect, stress out the already stressed.

The Merriam-Webster Dictionary defines coercion as "*the act, process, or power of compelling or forcing an individual to do something against their will by the use of psychological pressure, physical pressure, or threats".* Residential programs historically have had many coercive elements in their basic design. Beyond the overtly coercive practice of restraint and seclusion, milieu programming in residential treatment has a range of more subtly coercive aspects. Points-based behaviorally-focused level systems, prescriptive rules regarding many aspects of daily living, and even aspects of the physical environment can remove the sense of self-control and volition for the clients. These circumstances insidiously recreate experiences in which youth feel they have no control, feel the world is unsafe, or see relationships as unpredictable. These deeply engrained vulnerabilities reactivate the trauma-response systems in the brain, triggering automatic rather than thoughtful responses, and preventing the development of more adaptive coping strategies.

We do not suggest that it has been the intention of residential programs to create coercive environments, but rather seek to identify the potential impact of structures and provisions designed seemingly in the best interest of the clients to provide predictability, but which yield the unintended consequences of becoming persistent and subtle triggers. We also do not suggest the elimination of all structures and guidelines, but rather encourage thoughtful deliberation regarding the overt and covert effects of the nuanced details of milieu programming. Such deliberation should occur ideally in dialogue with the clients, and with an appreciation of their subjective experience of the caregiving environment, in a process that engages their ownership of milieu practices.

Restraint & Seclusion: Safety or Coercion?

Establishing a trauma-informed environment, in which there is little or no coercion, can go a long way toward reducing restraint and seclusion, and improving outcomes. The field has made great strides towards recognizing the coercive and deleterious impact of seclusion and restraint. Nonetheless programs still struggle with how to maintain safety and security in milieu settings, while simultaneously moving away from coercion.

An agency's establishment of philosophy and policies that mitigate the use of seclusion and restraint, as well as training in interpersonal approaches as alternatives to putting hands on youth, do not obviate the more nuanced moments when staff are required to decide how to best respond to a youth who is appearing to lose control, or who is behaving with severe aggression. In such moments, staff must decide whether putting hands on is absolutely necessary to maintain safety, as the likelihood is high that such a coercive act may recapitulate the client's earlier traumatic experiences of helplessness, and thereby perpetuate a cycle of retraumatization.

A key factor in this dynamic is the degree to which a parallel process is occurring internally for the staff. Various degrees of fear and anxiety emerge for staff in the face of violent behavior, as is a normal human response. Staff also respond automatically at times, with some form of fight, flight, or freeze. This may lead to immediate physical control of the situation, but does not generate the explicit thoughtful process through which the youth is more likely to learn self-control.

Although this situation presents a conundrum, residential programs are increasingly attempting to address it. Some are electing to not use seclusion or restraint at all, or are eliminating seclusion alone, but this can create a circumstance in which what may be an explicable temporary loss of control can lead to police involvement or hospitalization, at times not in the best interest of the youth. Some agencies, although decreasing in number, are not changing practice at all. An increasing number of organizations are providing training regarding the impact of overwhelming stress and trauma on brain development of the youth in care and using approaches that have been shown to reduce power struggles and escalations. What is key for organizations electing to or required to use emergency safety interventions is this: they must support staff with ongoing training to help them develop and utilize thoughtful (as opposed to automatic) responses to escalating situations. The Six Core Strategies © developed by the National

Technical Assistance Center is a great evidence-based resource. They must also implement policies that: specify “no force first”; delineate very clearly the rare circumstances in which restraint can be considered; and identify and provide for continual training in the restraint regime that is approved for these kinds of emergencies. Further, it is important that agencies recognize that direct-care staff are not immune to the effects of stress and trauma in their own pasts, and should offer trainings to enhance reflection, mindfulness, dialogue, and self-care.

The active and ongoing partnership of family members and youth in their treatment is a key practice in creating a culture in which coercion and its resultant power struggles are minimized to the point of elimination. When staff regards family members and youth as allies and partners in not only the individual treatment of each child but in the milieu, they establish a hopeful shared vision that mitigates power struggles and coercive responses to unmet expectations. There are a wealth of strategies, ranging from signage to promoting youth and family voice in all decisions and hiring peer advocates to teaching youth and family self-soothing and trauma-informed methods to practice at home, that will create a collaborative culture and limit hands-on events to rare episodes of significant dysregulation.

Organizational Factors

Expecting staff to establish a culture in which coercion is truly minimized, and explicit thoughtful intentional interaction is maximized, is facilitated by an overall organizational culture that is also non-coercive. Key models that foster non-coercive cultures such as Sanctuary, CPS, DBT, and TST, recognize the parallel process discussed in the previous section. Sustainable implementation of these models in the milieu is, to a significant degree, dependent upon whether similar approaches are mirrored within the organization. Thus, the challenge for organizations is to create an interpersonal environment that promotes dialogue, collaboration and a learning community, even within staffing structures that are typically hierarchically organized to facilitate accountability, efficiency, and clear role differentiation.

Maintaining a collaborative organizational approach that encompasses accountability for job performance is not easy, particularly in response to the myriad individual employee issues that arise, as well as human resource requirements and practice. A critical factor is for leaders to be very clear about expectations, not only those in personnel policies, but those that are more nuanced and relational in nature. In an organizational environment characterized by a sense of mutuality and reciprocity, in which staff groups and teams are engaged in decision-making within their scope and responsibility, staff are able to feel supported even when progressive discipline is necessary. Training of the supervisors and managers to implement the values and practices that create this culture is paramount, and involves both traditional supervision/leadership training available through human resources as well as clinical training regarding non-coercive approaches, applied to supervisory matters.

System Level Concerns

The dynamic tension between maintaining safety and creating non-coercive environments is pronounced at the system level. Local and state officials charged with oversight of residential programs have as a primary objective that youth are safe at all times. The natural tendency, given their mandate, is to be somewhat shy of what may appear to be elevated levels of risk and to require greater levels of control. In a parallel process to what occurs at the organizational and staff level, regulators and regulating entities face what at times appears to be competing directives- overseeing the creation of non-coercive therapeutic environments that foster long-term, enduring change versus ensuring safety at all times. In fact, the combined roles of oversight and regulation may at times confound the task of fostering non-coercive environments. The act of exacting compliance with federal, state, and/or local regulations places individuals assigned this task into a predictably controlling, coercive position; and this, of course, ups the ante when there are serious regulatory concerns regarding a program’s performance.

This is a difficult circumstance for residential providers to encounter. The provider influence on the regulatory environment is one that of necessity must emerge from dialogue. Explicating the parallel process that occurs between the regulatory response, the organizational response, and the staff response can be helpful. Utilizing the core interpersonal approaches of collaborative, non-coercive models can also be useful. For example, proactively and collaboratively approaching the regulatory environment to address

and resolve problems and issues helps set the stage for the emergence of a trauma-informed system that seeks to minimize the elements of coercion.

The challenge for regulatory officials is similar to that faced by organizational leaders. It is critical to ensure that expectations, including written requirements, are clear. Approaching a program's perceived or actual failure to comply with requirements with a spirit of partnership and a vision of positive outcomes for children, youth, and families can set the stage for collaborative solutions. Issuing sanctions in an even-handed and fair way, with a clear path to their removal, reinforces the sense of partnership. Maintaining clear dialogue and mutual expression of concerns throughout the regulatory process bolsters systemic efforts to create non-coercive treatment environments, and minimizes the overt and covert displays of power and control that do trickle down to the clients.

Conclusion

The growing body of neurobiological research supports the importance of systemic, organizational, and practitioner efforts to reduce and eliminate coercive structures, practices, and cultures. At all levels there are many strategies for creating non-coercive environments. Many resources are available which delineate these more specifically, most especially "Creating a Culture of Care" from the Massachusetts Department of Mental Health, the National Building Bridges Initiative, and previous Redefining Residential papers, including those on family-driven, youth-guided, and trauma-informed care.

AACRC urges its members as well as other practitioners in the field to learn more about and embrace the importance of establishing non-coercive treatment environments. Particularly in a world of increasing stressors, the young people and families we serve deserve no less - and our future in many ways depends upon it. For more information you may contact ACRC at (877) 332ACRC or www.togetherthevoice.org.