Moving from Control to Collaboration

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> If the person you are talking to doesn't appear to be listening, be patient. It may simply be that he has a small piece of fluff in his ear.
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> *Pooh's Little Instruction Book*, inspired by A.A. Milne

Moving from Control to Collaboration

Many treatment programs operate with an inherent philosophy that providers know what is best for the child, and that the child's behavior needs to be externally managed. This philosophy enforces an "us vs. them" mentality and creates harsh boundaries and distance between staff, children, and their families. Ross Greene, Ph.D. identified that staff control issues and reinforcement of rules were found to precede the majority of incidents of S/R (Greene, 2004). Below are four "slippery slopes" that may create problems when programs overemphasize control (Adapted from NETI Training Manual, 2004; Morrison, 1989).

Slippery Slope 1*:* The primary focus is on the needs of staff members rather than the treatment needs and goals of the clients. Treatment activities are organized around what is convenient.

Slippery Slope 2*:* Rules become very important and inflexible. Compliance and containment are valued and are sometimes mistaken for clinical improvement. There is a lack of recognition of client re-traumatization if and when it occurs.

Slippery Slope 3*:* Minor rule violations by children lead to control struggles with staff members. Privileges become a source of greater control struggles because staff members threaten to take them away when children don't comply or exhibit behavioral challenges.

Slippery Slope 4*:* Inexperienced or under-trained staff members bully children into compliance based on subjective observations about their behavior. Some programs reward staff for maintaining safety and having quiet shifts but do not realize that the results may have been achieved by using coercive methods.

Fortunately, there is a newer trend in treatment settings that focuses on minimizing the use of controlling practices in inpatient and residential treatment programs. These practices shift the emphasis from controlling behavior to forming collaborative partnerships with children and families. The underlying philosophy of the collaborative treatment approach is based on treating children, families, and staff members with dignity and respect.

Staff members view children as capable human beings and encourage and value input from children and their families in decision making. They respond to challenging behavior with empathy, active listening, and interventions that engage the children in finding solutions (NETI, 2004). Several treatment programs in Massachusetts that have significantly reduced S/R rates have also embraced collaborative approaches (LeBel, Stromberg, Duckworth et al., 2004).

Collaborative problem solving

Ross Greene, Ph.D., a well-known child psychologist in Massachusetts, developed a specific treatment model for children and adolescents, called *Collaborative and Proactive Solutions (*please see the short description in *Promising Practices,* Chapter 6). This approach focuses on understanding the child's behavior as a statement of frustration and recognizes that the circumstances that elicit the behavior are beyond the child's ability to manage.

The focus of the model and interventions is to engage in a problem-solving process to create greater understanding and help the child and family develop the skills to manage stressful situations (Greene, 2005). By using a collaborative and respectful approach, parents and staff members have found that they are often able to avoid power struggles.

Case example using a collaborative approach

Staff: "You are being restrained daily. How can we help you stay out of the safety coat?"
Adolescent: (firmly): "I *want* to be restrained."
Staff: "We have to think of other ways to help you feel safe. (pauses) Would a sleeping bag help?"
Adolescent (thinks for a moment): "Can I have the kind that gets tight at the end?"
Staff: "Yes, do you also want to use a weighted blanket on top?"
Adolescent (brightening): "Yeah…when can you get the bag for me?"

Applying a collaborative problem solving approach - One unit's success

The Cambridge Hospital Child Assessment Unit (CAU) in Cambridge, Massachusetts adopted Ross Greene's *Collaborative Problem Solving* approach, which helped them move from a culture of control to a culture of collaboration.

This approach helps staff members view a child's behavior as the result of an inability to tolerate frustration and recognize the child's difficulty with flexibility.

Staff members learn specific ways to interact with children to decrease "meltdowns" and to identify the pathways that lead to "meltdowns." Staff members emphasize teaching new skills to children so they can experience more success. One psychiatric resident who worked on the unit wrote, "When the leaders of the CAU started to think about changes, their first step was to change the mission from safety and containment to nurturance and teaching" (Harris, 2003).

Examples of how programs can develop collaborative practices:

1. Empowering staff members:

- **Staff empowerment**: Staff members should feel empowered and encouraged to make decisions that will help children gain control or calm down, even if they go against expected programmatic routines (allowing a child to stay up past bed time to talk, allowing a child to be late to class because he/she feels stressed, or allowing a child to leave a meeting and walk outside to calm down).

- **Staff are trained to use a collaborative approach**: Staff members should participate in on-going training in the areas of sensitivity, avoiding power struggles, and using collaborative approaches such as negotiation, alternative dispute resolution, conflict resolution, and collaborative problem solving.
- **Staff interactions**: Staff members should listen to each other's ideas, model mutual respect, and involve each other in programmatic decisions. Once staff members work collaboratively, there is a natural transfer to their work with children and families.

2. Make use of strength-based and skill-enhancing treatment practices

- **Showcase strengths**: Bulletin boards and program materials use words that emphasize strength, collaboration, choice, and empowerment.
- **Give children a voice in their care**: Children are encouraged and supported in taking active roles in their own care. Staff brainstorms with children about rules, activities, and incentives; staff and children work on weekly menus together; and family/child advocates are invited to help prepare the children and families for treatment meetings.

- **Staff members encourage family involvement**: Staff encourage family members to take active roles in their child's treatment, decision making, and planning. Meetings are scheduled based on family availability, there are open visiting hours, and the program provides support and education for family members.

How to turn coercive statements into collaborative statements

Coercive/Control	Collaborative
"I told you to go to your room, now!"	"Taisha, I am sorry I cannot talk right now because there is an emergency I have to address on the phone. Would you mind waiting in your room, or would you rather sit down in the office and wait?"
"Everybody line up, it is time to go to dinner. No talking when walking."	"We will be going to dinner in a few minutes. Remember, we must walk through halls quietly because people are working. Can some of you share with the new staff, Katie, some of the ways we try to be respectful when we walk to dinner?"

Coercive/Control	Collaborative
"Be quiet, it was not your turn to talk."	"Erik, I am so glad you want to participate. Do you think you can wait until it is your turn to share your ideas?"
"No, you cannot do your laundry another day. Get up and start your laundry now."	"Rasheed, I can understand that you want to finish your chess game. Do you want to do your laundry after the game or do you want to stop the game and ask Dean if he will trade with you? We only have the machines for two hours, so he'll want to start if he is going to trade."
"No, you cannot stay back from art class."	"I noticed you were acting different today. Are you sad or upset about something, or are you not feeling well?"
"No, you cannot just leave community meeting."	"I know it is hard for you to sit for a long time. I have the same problem. I use a squeeze ball whenever I get antsy. Do you think that would help you, or do you think using your mantra would help you feel comfortable staying longer?"

Coercive/Control	Collaborative
"If you don't participate in group, you will lose points."	"Wow, you usually love group. Do you want to talk about why you do not want to participate today?"
"If you don't take your medication, you will lose your privileges."	"I am really concerned about you feeling good. Do you think your medication is not working, or is it making you feel bad or different?"
"Are you questioning my authority?"	"From the way you responded, it sounds like I might have been too forceful when I told you to stop watching TV. Lanette, if we are going to make the movies in time, we need to leave now. I know you wanted to go. Do you still want to go or do you want to stay and watch the program?"

Positive outcomes in programs using collaborative approaches

The following positive outcomes have been noted in programs in Massachusetts that are using collaborative treatment approaches:

- Decreased use of S/R
- Relationships are nurtured between staff, children, and families
- Staff members use empathy and support to help children participate in the program to the greatest extent possible. They use a variety of tools to help children stay calm and in control
- Children and staff learn new ways to solve problems
- Staff recognize that all behavior is meaningful, and challenging behavior indicates that a child's needs are not being met. They work to understand what the child is trying to communicate through his/her behavior. Staff think about how they can respond to the behaviors, using concepts such as "giving a child a flashlight because he is lost in the dark," "helping a child succeed by taking away roadblocks," or "acting as a tour guide to support a child out of a mess."
- After a difficult behavioral episode, staff members tell the child, "I am sorry you were upset and we did not help you stay calm. Can you think of something we could have done to be more helpful?"

- Staff, children and families all feel more satisfied with the program.
- Children have reduced lengths of stay in out-of-home programs that actively partner with families (Stroul & Friedman, 1986).

Collaboration

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