CHILD MANAGEMENT & DISCIPLINE
Jasper Mountain's Approach

This statement describes how the agency approaches child discipline, and how situations are handled when a child has become unsafe to himself/herself/themselves or to others.

In a total therapeutic environment, the most potent vehicle for treatment is every staff/child, child/child and child/environment interaction. Therefore, every interaction must be seen as significant and purposeful. In Agency residential programs, child management is not simply a question of behavioral control and discipline is not just a way to extinguish problem behavior. Within the treatment environment, child management becomes instruction, modeling, and effective and responsive communication. Discipline follows the meaning of the term itself, which is "to teach." In other words, discipline is not a fancy word for punishment at Jasper Mountain. It is the foundation of behavior management as well as socialization. The goal is the real time instruction of appropriate social and interpersonal attitudes and behaviors. It is important to refer here to the mission and program philosophy that must guide all aspects of client care.

Discipline follows the meaning of the term itself, which is "to teach."

Overview of Approach

The principles of positive discipline shall be followed as outlined in staff training. No physical punishment will be used, nor will any other type of punishment, including withholding of basic needs, be allowed. Logical consequences are usually the best teaching tools. Regardless of the intervention, its effect on the child and the situation is to be monitored for efficacy and altered if the results are insufficient or producing negative side effects.

In the agency's approach to behavior management, the personal safety and personal worth of all clients are to be always of the uppermost importance.

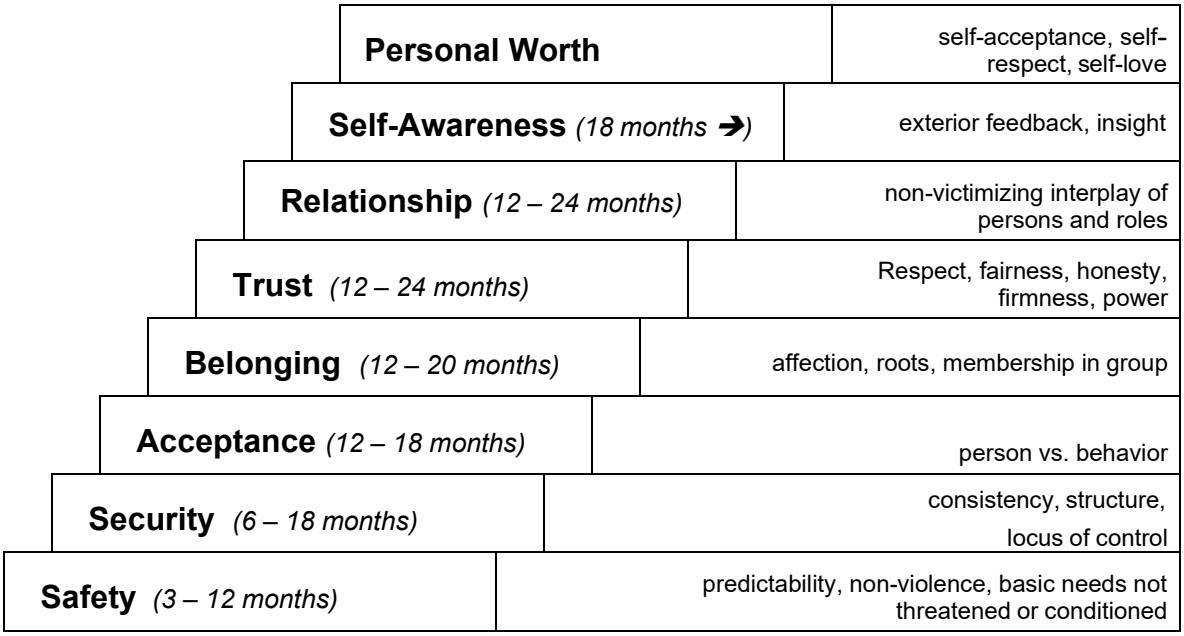
Specific interventions will be developed cognizant of the treatment plans for individual children. In this context, the personal safety and personal worth of all residents shall always be paramount. Violent behavior will not be allowed to occur without direct intervention. This is essential to the physical and emotional safety of everyone.Physical interventions will follow the principles of NonviolentCrisis Intervention as outlined by the Crisis Prevention Institute (CPI), with attention to the conditions and setting. All

interventions will be consistent with the treatment plan and according to the Agency policy on interventions. Any violent incident shall be immediately reported to the lead staff and to the appropriate program director as soon as possible. As often as possible, physical interventions that constitute a containment hold are to have more than one staff, interventions that do not constitute a hold should be observed by more than one staff.

The Agency uses several methods to insure safe, effective, and best practices in the area of behavior management. Agency programs compile data on therapeutic holds. This information is reviewed on a monthly basis by the Quality Assurance Committee. The Agency data is compared to other treatment programs serving similar populations. The Board of Directors receives a program report each quarter that addresses the use of behavior management practices within the Agency. The Management Team is to annually review the Agency's use of behavior management practices to ensure compliance with State and Federal law as well as best practices for treatment programs. Other principles of management and discipline will be addressed specific to individual children and in staff meetings and trainings.

Building Blocks of Treating Emotional Disturbance

Child management and discipline must also be viewed within the context of the "Building Blocks of Emotional Disturbance." Fundamental is that the parental figuresfor small children must always be firmly and responsibly in control of the environment. Management is a key to safety and security, and the first and most essential aspect of a treatment environment. Management means that at all times the children are aware that the staff are making the decisions in a safe and responsible way. In addition, the program must be free from conditions that promote maladaptive behavior.



Jasper Mountain Interventions

Over the years, new staff members have repeatedly asked for an explanation of how and when interventions are to take place in the Agency. Most of the time what they have been asking for is an easy-to-understand formula as to what they should do in a certain situation. However, a formula or cookbook approach to interventions has been resisted since the Agency began. Instead, staff have been trained and encouraged to become skilled clinicians with a growing understanding of the nuanced qualities of treating children. While we strive for staff who are skilled and creative in working with difficult populations, we must recognize the rules and guidelines of interventions directed by the Center for Medicaid Services, Oregon Addictions and Mental Health, the Crisis Prevention Institute, and the Council on Accreditation. The interventions outlined here have been carefully develop by the Management Team with input from agency trainers, program directors, and national priorities and requirements. The following position statement is both a policy and procedure. It is meant to outline the philosophy of the Agency regarding therapeutic interventions, and to describe the Agency's practical approach to working with difficult to manage children. While some organizations subscribe to a behavior management system developed elsewhere, Jasper Mountain has such a uniquely challenging population that the organization has developed an approach taking ideas from numerous sources. The following position statement will stress that interventions are to be individualized, that alternatives are considered, and that when physical interventions are required to keep a child and others in the environment safe, these interventions are to be done appropriately and safely. This policy and the procedures outlined are intended to be in compliance with all federal regulations (42 CFR Part 483 Subpart G) including the Department of Health and Human Services' Addictions and Mental Health rule governing restraint and seclusion as well as all State of Oregon regulations including Senate Bill 710 (enacted 9/1/2021) as well as the State of California EC 49001; EC 56520; EC 56523.

THE PURPOSE OF INTERVENTIONS

The word "intervention" is a generic term to indicate the way steps are taken to accomplish a prescribed goal. Treatment programs are fundamentally about accomplishing prescribed goals and are therefore fundamentally about interventions. Over time therapeutic interventions, be they verbal, nonverbal, physical, environmental, or chemical, have maintained a positive and important place in the function of a treatment center. Although this is still the case, the modern world of regulations and liability have placed a questioning spotlight on physical interventions. In some ways this is good; a heightened awareness brings more effective physical interventions. However, this focus has often put a very effective form of treatment into a category of a crisis, and this line of thinking maintains that all crises are best prevented. Understanding intensive treatment and its purpose, however, includes the understanding that in a treatment setting, problems cannot be ignored, behaviors cannot be allowed to go underground, and explosive issues cannot simply be avoided with skilled crisis prevention. At the same time interventions must be safe and appropriate to the child, to the situation, and to the overall plan of care. While agency managers determine which interventions are

approved, the case manager and care team, including the parent/guardian of the child, determine specific interventions for a particular child.

Two important components of treatment interventions are to build upon strengths and to address the deficiencies of each child. When possible, building upon strengths can be the most potent agent of change. Jasper Mountain has multiple treatment components that build upon strengths, particularly where staff catch children doing well and not just seeing problems. Some of the strength-based components include the Gemstones incentive program, equestrian therapy, arts and crafts, sports and therapeutic recreation, and much more. Addressing the causes of deficiencies of children must include addressing emotional and behavioral issues using the Jasper Mountain approach of transforming the child from the inside out. For example, evidence-based practices for trauma treatment must include re-exposure to issues that can cause emotional and behavioral reactions. If the issues that produce emotional tension and serious behavior problems are carefullyavoided, then serious behavior will likely return within the family and community settings, where adults may not be prepared to respond safely and effectively. It is important to know how to prevent a crisis, but it is not always clinically optimal that all treatment enhancing situations of this type be avoided or prevented. The Agency does collect data on physical interventions, but we do not do this only to reduce the frequency of such events. Simply reducing as many physical interventions as possible ignores the responsibility of treating and changing, and not just temporarily preventing, problem behavior.

The purpose of residential treatment is to help each child achieve his/her/their individual treatment goals in the most expeditious way possible while using the interventions which would be most helpful for each unique situation. Clinically appropriate interventions, therefore, are not good or bad; they are effective or ineffective. Saying that one form of intervention in all cases is better than other forms is to not understand the purpose of a treatment program. The Agency is committed to reducing all unnecessary and non-therapeutic interventions, including, but not limited to, containment holds. But given a treatment center's goal to help each unique child within its care, it is important that the staff have the latitude to use all interventions that are safe and clinically appropriate, given the needs of each individual child.

CLINICALLY APPROPRIATE INTERVENTIONS

This section begins by stating which interventions are not appropriate for use at Jasper Mountain. Mechanical restraint devices are never used, and the Agency does not believe in the concept of seclusion rooms for isolating traumatized children. Children may need to be removed from the presence of other children if they are being physically or verbally abusive to others, but children temporarily removed from other children due to serious behavior risks are to be supervised and in the presence of staff and never left alone.

In addition to these exclusions, no type of punishing, harmful, painful, or punitive interventions are appropriate in the Agency's treatment programs. Specifically, the Agency prohibits degrading punishment, corporal or physical punishment, painful or aversive stimuli, forced physical exercise, punitive work assignments, group punishment for one person's behavior, medication for punishment, mechanical restraints, extended isolation without contact with peers or staff, depriving children of food or other basic needs, and preventing contact with family members when contact is not prohibited and a part of the treatment plan. The Agency also does not permit the use of chemical restraint to control serious behavior. All physical interventions used are within the guidelines of the State of Oregon's approved crisis management system, the Crisis Prevention Institute (CPI).

The array of the Agency's approved interventions will be described in the next sections, including verbal, non-verbal, chemical, physical, and environmental interventions. Of these options, physical interventions will receive the most attention, but this is not because they are the preferred intervention. Rather, it is because most educational settings, college courses, and training programs cover verbal interventions effectively, and staff members coming into a treatment program are generally much more knowledgeable about verbal and non-physical interventions than physical ones. In addition, the modern climate of mental health services seems to focus largely on limiting or eliminating physical interventions. Consequently, it is important that staff be educated regarding the clinically appropriate reasons for including physical interventions in the treatment setting, and the ways to use such interventions both safely and effectively.

COGNITIVE RESTRUCTURING INTERVENTION
A Research Based Method of Treatment and Behavior Management

The Agency does not agree with the management approach known as a "time-out," due to its punitive nature (the child is sentenced to an amount of time for some wrong- doing). Instead, the Agency uses an approach that promotes changes in the way the child's brain responds to situations the child encounters. This approach is called Cognitive Restructuring.

Cognitive Restructuring (CR) is a method to retrain the brain of children who experience the chronic effects of trauma and/or emotional disturbances. Briefly stated, CR aids the child in moving from neurological patterns of fight or flight or freeze reactions toward newpatterns of higher-order reasoning and executive functions taking place in the brain. This method can be used anywhere and at any time. As well, it can have immediate and long-term positive implications for a child's recovery and social success.
Cognitive Restructuring is supported by years of brain research that identifies the neurological region of the brain housing the fight or flight response of the limbicsystem, specifically the amygdala. The amygdala is the fear center of the brain. It is activated by

intense stressors in life in the short-term and is chronically activated by significant traumatic experience. Brain research also identifies the higher reasoning centers of the brain housed in the neocortex and specifically in the prefrontal lobes of the brain. These are the regions of executive functions such as, planning, thoughtful consideration, cause and effect, delaying gratification, inductive and deductivereasoning, and many other essential thought processes. Stated briefly, traumatic experience produces a reactive, fear-based response to new stress. Cognitive restructuring helps the child reduce fear and reactivity and encourages better use of cognitive skills resulting in prosocial behavior. Research has shown that the brain adapts with new neuro-templates with repetition. As with any skill, CR takes practice and repetition. Therefore, the more this skill is practiced, the stronger it is imprinted into neuropathways in the brain.

In a way, CR is the primary process of all trauma and rehabilitative therapies. This process moves an individual from being a reactor to an actor, from someone who is victimized by the world to someone who successfully negotiates through the challenges of life. Cognitive Restructuring can be explained in complex neurological terminology or in easy-to-understand practical terms. The practical description above forms the basis for effective behavior management approaches to children who are reactive, impulsive and appear unable to think through challenges in life.

The Three "R's" - As a behavior management approach, CR provides the child with what is missing in their life: training in full-use of their own brain power. A child at any age can learn the quick and easy steps to CR. These steps have been described as the three "R's," Relax, Rethink, and Respond. These easy to remember steps can helpboth the child and the adult to remember the important components of CR training of the brain.

Relax – Recent evidence-based research indicates that among the most powerful interventions for multiple types of emotional disturbances is training in relaxation. This step not only can immediately change cognitive functioning and move the child from processing in the limbic system to the neocortex, but it also can have an immediate calming influence on behaviors and emotions. Hundreds of methods of relaxation have been studied and essentially all work if they reduce autonomic arousal, reduce blood pressure, and reduce reactive stress. Easy methods have been taught to children for decades such as: count to 10, take several deep breaths, close your eyes and go to a calm place you have been before, or many other similar approaches.

Rethink – After some relaxation has been achieved, the brain is more available to use higher reasoning centers. For this step, the child will usually need outside coaching at first to see possibilities other than habitual negative reactivity. As a practical step, this involves the adult helping the child think about the situation. For instance, what has happened, whatchoices the child has for potential responses, and what alternatives might produce better outcomes than others. Considering these questions helps the child use self-reflection to better understand cause and effect and the results of the decisions the child makes. This assistance from staff encourages the child to use reasoning-centers of

the brain.

Respond – Only when the child is using higher-order thinking can he or she see the alternative to negative, reactive behavior; that is, to respond to the situation in a way that will result in positive outcomes. The ability to respond rather than react is the keyto regaining self-regulation, the lack of which is the most pervasive result of childhood trauma.

The most helpful aspect of the three "R's" process for the child is not how well they learn at any one time, but how often they engage in this process. Each repetition results in real changes in the brain, real stress reduction, and real experience in exerting internal personal power to change the world that the child has previously experienced as overwhelming and more than he/she/they can cope with.

The CR process and intervention is as effective as the adult using it. The fundamental steps include the three "R's" *with* the connection, assistance, and encouragement from the adult. This is not a process the child can do alone, or they would have done so in the first place.

There is one more "R" that is critical in this process and that is Repetition. It is in repetition that new patterns of behavior are developed and more importantly that new neuropathways change the structure of the brain, subsequently optimizing the executive functions that provide the child with the building blocks of social and personal success.

VERBAL INTERVENTIONS

Clinicians usually rely heavily on verbal communication because they are most comfortable interacting on a verbal level. Training programs designed for therapists emphasize what is said to a client more so than any other form of communication. With preadolescent children, however, verbal therapies and interventions are often not as effective as other forms. In fact, one of the most important principles to understand concerning verbal communication with children, is its limitations. Limitations may include a child's limited receptive language skills, difficulty understanding the verbal communication of adults due to neurological stress reactions, and many other limitations such as the difficulty some children have understanding the real meaning of

verbal messages or hearing all, and not just some, of what is said. It is important with young children not to overly rely on words.

Yet, verbal interventions are still a critical aspect of an effective treatment program. The basic verbal skills of communication such as active listening skills, attending behavior, tracking, reflection, summarization, and many others are important for all Agency staff to be familiar with. These verbal skills will be taught in agency trainings but will not be covered here. However, staff should be cautious not to overly rely on verbal interventions to teach, to counsel, to calm down, to provide reassurance, or to facilitate various aspects of socialization. Words can be powerful in some treatment situations, but they are only one way to intervene.

NONVERBAL INTERVENTIONS

Words are less than 25% of any interchange between people. Facial expression, posture, tone, cadence, volume, gestures, and other components of communication add to the full meaning of words. Children are particularly sensitive to nonverbal messages, as they have learned to read nonverbal messages from their caretakers long before they could understand verbal messages. Due to previous abuse, many children are hypersensitive to nonverbal messages and may completely miss what is being said. Most children in treatment settings have also refined their ability to have the words of adults "go in one ear and out the other." An effective clinician, therefore, will need toknow how to use nonverbal communication to achieve therapeutic goals. Most educational programs in the field of social sciences will cover nonverbal communication. In a residential treatment setting, these skills will be further developed through experience and awareness. Staff should remember that actions do speak louder than words in treatment settings, as well as in homes and schools. Children will primarily learn by watching the modeling demonstrated by adults. How a staff person handles feelings, conflicts, and frustrations is far more important than what that staff person tells a child about these things.

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CHEMICAL INTERVENTIONS/THERAPEUTIC MEDICATIONS

Physical interventions are not the only controversial topic in treatment approaches. Some programs have a philosophical leaning toward the use of chemical interventions, and some lean away from their use. Jasper Mountain takes no position promoting or discouraging the use of chemical interventions, other than not permitting chemical restraint. When a child has serious behavioral problems, chemical restraint and mechanical restraint are never allowed. Regarding other uses, however, the Agency

does take the position that if a chemical intervention can safely facilitate treatment progress for a child, it will be considered. External progress must always be weighted with empowering the child to make internal gains as well. If a chemical intervention is chosen, the best approach is to effectively take advantage of the intervention by using a therapeutic dosage and not to over- or under-medicate. Medications should be linked with encouraging the child to make internal changes and demonstrate self-regulation.

Specific decisions concerning the use of therapeutic medications are made by the psychiatrist and the family with consultation from the treatment staff. Although the psychiatrist determines the medication, a basic knowledge of chemical interventions by treatment staff will also enhance the effectiveness of this intervention. Psychopharmacology is an extremely complex area of medicine and physiology, but even so, all treatment staff should expose themselves to the Agency's training materials, and develop a basic understanding of how medications work on the brain and how specific medications affect behavior.

PURPOSE OF PHYSICAL INTERVENTIONS

The first language of the child is touch. Research has shown the critical importance of basic human touch to physical growth, cognitive development, and personal and social attachment. Because touch is the primary language of children, treatment programs for young children that do not use touch or that take a "hands-off" approach are missing many therapeutic opportunities. An effective treatment program will use touch as a potent means of communication and teaching.

Physical interventions, therefore, are not restricted to intervening with an out-of-control child. Physical interventions include any situation where there is a therapeutic gain possible through physical touch.Depending upon the situation, this might include a hug, a back rub, a hand on a shoulder, sitting close to a child, giving a child a piggyback ride, holding a child's hand, or a host of other behaviors nurturing parents use with their children. Too often people think of physical interventions as negative interactions whenthere are problems. At times, the lack of physical touch may promote a crisis in a child with emotional disturbances. It is often the case that the types of interventions mentioned above can also help desensitize a traumatized child to negativeassociation with physical touch from the child's past. Desensitizing reactions to touch in traumatized children is a recognized evidenced-based method in treating post-trauma reactivity and anxiety disorders.

Physical interventions includeany situation where there is a therapeutic gain possible through healthy, appropriate, and consensual physical touch.

As stated earlier, in the controlled setting of a treatment center, not all emotionally

laden issues and situations that might bring out intense reactions and behaviors (which some would call a crisis) are to be prevented. The role of the treatment center is to accomplish the treatment goals of each unique child. It would be a failure for a treatment center to graduate a child who, with the assistance of trained staff, has avoided situations that precipitate antisocial reactions, reactions which then would come out at home or in school after leaving the tightly controlled setting.

Despite some people who believe otherwise, the Agency's position is that clinically appropriate physical interventions are not negative, punitive, or a symbol of failure on the part of the child, the family, or the staff person. As such, the organization doesnot take steps to reduce or eliminate approved interventions. Rather, the QualityAssurance Committee and Management Team both work to reduce or eliminate interventions with little or no therapeutic value among the interventions that are approved by policy. Non-therapeutic interventions are first identified by shift leaders, then by program directors who review all incidents, and finally by the Management Team. When an intervention is deemed to be ineffective or lacking in therapeutic value for a specific child in a specific situation, additional training is provided to the staff and new instructions are developed including changes in the child's individual behavior management plan. The Executive Director, in consultation with agency crisis trainers, review the national literature for emerging themes in behavior management. Agency trainers also receive information from our crisis intervention system, CPI. The organization also participates in information exchange with theory and practice regarding behavior management.

Fundamentally, the organization bases its position on behavior intervention with the acknowledgement that children need physical touch and tangible reminders that competent and caring adults are working with them. Emotionally disturbed children need these reminders more than other children. National research indicates that young children, such as those in our programs, have violentbehaviors more frequently than older adolescents. When used in the right way and at the right time, physical interventions can be some of the most potent aspects of a clinical regimen, particularly in the early stages of a child's residential stay.

In summary, there are a variety of reasons to physically intervene with a child in a treatment center. Physical touch is one of the basic needs of every child. All these reasons can be consolidated to say that a physical intervention is designed to let a child know that you are there, you are prepared to handle any problem, and the child is safe and in good hands. Your presence in these ways constitutes safety and predictability for the child these are the most basic human needs and rights for all children.

TYPES OF PHYSICAL INTERVENTIONS

Before discussing specifics regarding more restrictive physical interventions, it is important to emphasize the Agency's concept of being "firm and friendly." According to our program philosophy, the balance of firmness and caring is important to avoid manipulation by the child (firmness) and avoiding the perception of punishment (friendly). This does not mean that a staff person can be both firm and friendly in every

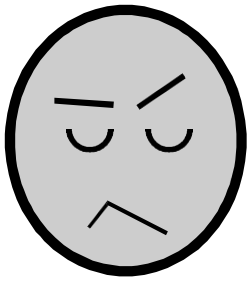
situation simultaneously. Many situations do not allow this. It does mean that overall, a staff member must be able to establish a relationship with a child that is characterized by firmness (or the staff will not be respected or taken seriously), and friendliness (or the staff will be viewed as another punitive adult in the child's life). For most physical interventions, if the intervention is both firm and friendly, the staff member will come out ahead and so will the child.

Behavioral redirections that are used before a containment hold: There are many interventions using supportive physical touch that can help calm a child or deescalate a child's emotions and behaviors. Many of these have been mentioned: touching a child's arm or shoulders, holding his/her/their hand, and other uses of supportive touch and close physical proximity to the child. When this is done in the right way and at the right time, it can answer the questions behind a child's testing behavior and can at the same time be very reassuring to the child. Later, many children can admit that it was good to know that the adult set limits and then acted to enforce those limits. In translating the meaning of a child's behavior, do not overlook the obvious. If a young child knows that a certain violent behavior will end up in an adult physically preventing violent behavior, there is a good possibility that the child wants to bereassured by the adult's physical touch. Children are not always testing when they act in a way that is unsafe. At times, they may have reached their limit to be able to handle the emotional demands of a situation and begin to act in violent or other hurtful ways either to themselves or others. When a child becomes violent, immediate steps must be taken to contain the potentially dangerous results. This is one of the most critical times for a traumatized child to hear, see, and feel the reassuring protection of an adult who isacting in the child's best interests.

An intervention that has not yet been discussed is the need at times to physically move a child from a situation that may escalate into a safety concern. Young children may need to be physically moved when they do not perceive the danger in a situation.Older children may need to be removed from a situation where the child is intimidatinganother child or is being intimidated. There may be a variety of situations where a staff person may need to have a child move from or to a different setting. If a child has developed a habit of running from adults into unsafe situations, the adult may need to physically prevent this unsafe behavior. The behavior of some children may present a risk to other children. It is important to consider all factors in situations that may require a staff to intervene in a physical way to ensure safety with the least restrictive methods possible. The child's behavior management plan should identify the special intervention needs of the child. The behavior management plan is written by the Jasper Mountain Team, including the program managers with input from intake information, the parents/guardians, care team, therapist, and psychiatrist. The behavior management plan includes information about the child's history, primary problems, interventions that have been effective and ineffective, special treatment procedures approved and not approved and recommended interventions for the specific child. Behavior management plans are agreed to by the parent/guardian and are reviewed monthly and revised, when necessary, by the therapist and care team for the child.

When situations arise where there is a need for a child to move from a location, staff are to use crisis prevention training to accomplish this. First, verbal skills should be used, and the child should be provided the opportunity to cooperate with staff. If the child does not voluntarily comply then the staff could provide choices to the child that may involve consequences for lack of cooperation. If the child needs further encouragement the staff could use humor, holding the child's hand, or putting a hand on the child's shoulder in a supportive way. Consistent with federal and state statutes, if more than limited physical force is needed to maintain safety in the situation and the physical intervention involuntarily restricts the child's movement, then the intervention meets the definition of a containment hold. To move to a containment, the actions of the child must constitute a danger to self or others.

Containment holds: In addition to the interventions mentioned thus far, there are interventions of a firmer physical nature. State of Oregon administrative 309-022-0175 defines personal restraint the same as the Federal definition, that is, the application of physical force without the use of any device, for the purpose of restraining the free movement of an individual's body to protect the individual, or others, from immediate harm (Oregon Health Authority: https://secure.sos.state.or.us/oard). Personal restraint does not include briefly holding without undue force an individual to calm or comfort him/her/them or holding an individual's hand to safely escort him/her/them from one area to another. All physical interventions that fit within these definitions, which the Agency refers to as a containment hold, will follow Agency, State and Federal guidelines, and will be authorized by the treatment plan and documented in an approved manner. Interventions used in the agency are to be consistent with the Crisis Prevention Institute (CPI). Additional policies on physical interventions to meet the Federal Department of Health & Human Services rules (42 CFR Part 483 Subpart G), can be found in 2.A.5. Special Treatment Procedures. Information on the 2021 Oregon Senate Bill 710 amendments can be found here: https://olis.oregonlegislature.gov/liz/2021R1/Downloads/MeasureDocument/SB0710/Introduced.

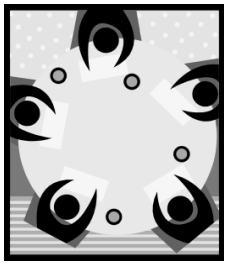


For our Agency purposes, the term "restraint" is not the best of words. It means something mechanical to many people. In a psychiatric residential treatment setting, a restraint is a therapeutic hold used to partially or fully contain a child to prevent potential harm to self or others. Such restraints usually involve containing the child's body, arms, and legs, all of which are most frequently used by young children to be violent to self or others. Since the child is either being violent to self or others, the child usually responds to being restrained by resisting or by physically testing to see if the adults have control of the situation. Once these violent children find that the adults have control of the situation, they often see if they can emotionally be more powerful, just as they have been over other adults in their past. This striving for power often takes the form of screaming, head butting, verbal insults, or yelling that they are being hurt or that the adults providing the support are child abusers. For many of the children coming into our programs with violent pasts, they will often need to go through this period of testing before they can see

that in these situations, the adults can manage the child's violent behavior safely by preventing the child or anyone from being hurt. For many emotionally disturbed children, only after this testing has occurred can they begin to take the steps of moving beyond the violent and controlling behavior that hides their fear, sadness, and pain. If a staff person and the treatment program cannot get to the place of reassuring protection, the therapeutic work will often not occur.

Containment holds are only appropriate in emergency situations where there is an inherent threat of harm. Based upon this threat, the goal of the intervention is to prevent immediate harm to the child and to others in the environment. When a containment hold is necessary, it is essential that the staff are as calm as possible to handle the situation wisely and with the least amount of physical force necessary. The staff need to send a signal to the child that the potentially violent situation is under control. It is critical to abused children that, during holds, the child is treated appropriately and respectfully, or they could link you with past abusers. During the hold, the staff are to ensure the safety and well-being of the child including physical and psychological well-being. It is important that the hold not involve physical pain or interfere with respiration. The child's psychological state is also to be monitored by the staff involved and any concerns are to be immediately reported to the hold authorizer and the shift leader. Respectful treatment of the child must be modeled if the child is expected to act respectfully in return. It is also important that the child experiences that he/she/they have dignity and rights that will notbe violated. It is important to remember that the child's first right is to be safe.

Monitoring of Behavior Management Practices: In addition to extensive training, the Agency uses several methods to additionally ensure safe, effective practices in the area of behavior management. Agency programs compile data on therapeutic holds. This information is reviewed on a monthly basis by the Quality Assurance Committee. The Board of Directors receives a program report each quarter that addresses the use of behavior management practices within the agency. In addition, the Management Team annually reviews the Agency's use of behavior managementpractices to ensure compliance with State and Federal law as well as safe, effective practices for treatment programs. Other principles of management and discipline will be addressed specific to individual children and in staff meetings and trainings.



ENVIRONMENTAL INTERVENTIONS

It is a fundamental belief of Jasper Mountain that the most potent influence on children is the synergy of all aspects of the child's environment. This environment is composed of the atmosphere, the architecture, the people, the lighting, the sound, the activities, the relationships, and all other components that interact and interplay to form the treatment

environment. Considerable energy has gone into the physical qualities of Agency programs. To develop the optimum impact of environment as an intervention, it is important to understand the effect of all the aspects of a child's life, and how they create a positive or negative influence. In the final analysis, our programs will succeed or fail not on the basis of individual therapy, medications, skilled verbal or physical interventions, or any other single aspect of the program. It will be the overall environment that will promote or delay the child's progress toward an integration of theiroverall health and personal and social development.

Special Treatment Procedures **(See Appendix A)**

As defined by the State of Oregon, special treatment procedures include physical holds, seclusion, experimental practices, and research projects that involve risk to the child, as well as staff-directed removal of the child from the program for specific periods of time. Of these special procedures, Jasper Mountain does not allow seclusion, experimental practices, or research that involves risk for the children. The organization also does not allow any intervention that is designed to cause physical or emotional pain, any form of physical coercion, or physically intrusive interventions other than to protect the child and others from harm. As explained previously, physical holds can be a necessary and important aspect of treatment. In addition, children who pose a risk to others may need to be temporarily removed from the social milieu to maintain safety for all.

CONTEXT FOR SPECIAL TREATMENT PROCEDURES

The building blocks of treating emotionally disturbed children begin with safety. The Agency believes that traumatized children cannot heal and develop in an environment where safety is a concern. To assure this for all children, patterns of violent and aggressive behavior by many children coming into the program must be handled directly and safely. Children have the right to make free choices and grow in their level of self-determination. At the same time, children do not have the right to place other children in jeopardy. The balance of these two rights requires the staff of Jasper Mountain to appropriately handle situations where violence occurs in the programs.

In accomplishing this task, all interventions are to be instituted in the safest manner possible. The Agency will provide all staff members who have supervisory responsibility for children training leading to certification in the State approved crisis intervention system, via the Crisis Prevention Institute (CPI). New staff will receive the initial certification course, which must be renewed bi-annually. Recertification will include at least three hours of refresher training, in accordance with CPI training standards. Additional training and instruction is provided by Agency trainers on shifts and in supervision, including understanding behaviors that come from psychiatric disorders, less restrictive interventions, assessment of environmental issues, de-escalation techniques, mediation, active listening, signs of physical or psychological distress, and practical application for specific residents or settings.

At times, the child's family asks Jasper Mountain to use alternative interventions that the family believes in or has used in the past. We consider these interventions based upon their efficacy, research support, and alignment with Federal and State regulations. When requested interventions are not appropriate in this setting in the opinion of the Management Team, the family is informed of the decision and is given the reasons behind the decision. At times an unconventional practice is approved for an individual child, usually after consultation with the child's psychiatrist and/or pediatrician. In such cases the results of the practices are monitored closely for effectiveness.

INDIVIDUALIZED PLAN & APPROVAL FROM GUARDIANS

Parents are to be informed verbally and in writing of interventions used in the Agency during the intake process. Policies and procedures are to be provided to guardians at intake to obtain agreement with organizational approaches, particularly the conditions under which approved holds and special treatment procedures will be used. It is the responsibility of the program director to insure this is accomplished at intake. Upon a child's admission, the parent or guardian is provided the Agency's written policy on containment holds (including contact information for Disability Rights Oregon, the State Protection and Advocacy organization) and the Agency requires signed documentation that this has been received. Verbal information is also provided to the parent/guardian. The Agency will ensure the policy is understood and will provide any accommodations needed, such as an interpreter. Per Senate Bill 710, the child will also be informed of behavior control methods in a manner the child can understand.

In addition to this general orientation, an individual behavior management plan is developed for each child with the input of parents, guardians, and the clinical team. This plan indicates the techniques to be used that have the best chance of success with the child. It is based on the child's history of violent behavior toward self and others and types of interventions that have worked and not worked. The plan also outlines special treatment procedures that may be used, therapeutic alternatives and methods to reduce the necessity of such use. If the clinical team anticipates a need to use containment holds to prevent injury or violent behavior, this is to be stated in the child's plan and less restrictive alternative interventions are also to be identified, to be implemented first by staff when possible. In addition, if there are interventions approved by the Agency and contraindicated for a specific child, this is to be noted.

The parent/guardian(s) are also to participate in the ongoing review of special treatment procedure interventions used with their child. As the treatment placement proceeds, they are informed when there are critical incidents requiring crisis intervention. At clinical review meetings, parents/guardians are also given an opportunity to discuss the policy or specific interventions used with their child, as well as the outcome of those interventions. Finally, the child's treatment and behavioral plans are reviewed for effectiveness on a continuous basis by the therapist, guardian, and clinical review team at the monthly clinical review meetings on the child.

AGENCY MONITORING & REVIEW OF SPECIAL PROCEDURES

To ensure compliance with Agency policy on special treatment procedures, the Quality Assurance Committee shall function as the Special Treatment Procedures Committee and is charged with monitoring and assuring compliance in the procedures used in Agency programs. The needs of other children in the area of the emotionally externalizing child must be taken into consideration as well as the child having difficulty. Jasper Mountain does not allow intimidation, threats, physical or verbal violence, or harassment of any type from one client to another. Therefore, the first task is to safeguard the rights of all children in the program, both the child who may be having an explosive incident and the other children in the environment. The Quality Assurance Committee shall provide a written review of special treatment procedures including findings and recommendations each month. As stated earlier, the use of chemical restraint or mechanical devices are not allowed at any time. Research within Agency programs must be approved in advance by the Board of Director's Institutional Review Board and by the State regulatory department (DHS and/or AMH).

To facilitate this regular oversight, the Quality Assurance Committee is guided by several threshold indicators that activate further consideration and possible adjustments. These thresholds include, a pattern of special treatment procedures with one child, a pattern of procedures from one staff person, a pattern of procedures between one staff and one child, a removal of a child from the milieu for over two hours, removal of a child from the milieu for an accumulated five hours over five days, interventions that meet the State definition of "personal restraint," any physical intervention for thirty minutes or more, physical interventions for an accumulated five hours over five days, and any combination of the above that would indicate a concern for the impact on the child or concern that the Agency's policy on interventions is not being followed.

In addition to the QA review of these factors, if any of the above thresholds occur for an individual child, the Agency psychiatrist or designee will, within twenty-four hours of the event, arrange by phone or in person the various individual(s) in the program with designated clinical leadership responsibilities to review the child's individual plan of care and/or behavior management interventions to make any necessary adjustments. Cumulative data on removals and interventions falling under the definition of "personal restraint" will be reviewed in clinical review meetings for each child.

The QA Committee includes all members of the Management Team. The Management Team is responsible for ongoing review of National best practices in the area of behavior management and adjusting the Agency's policy and practices regarding interventions. The Management shall obtain external consultation on behavior management when called for and will use monthly intervention data to modify practices and training of staff as needed. Interventions will be considered according to their therapeutic benefit and non-therapeutic interventions will be the target of reduction and elimination.

Finally, in addition to this clinical oversight and the monthly QA audit, the Quality Assurance Committee presents quarterly reports to the Board of Directors regarding the

material, and the actual policy is reviewed annually by the Management Team for any necessary adjustments.

PROTOCOLS FOR SPECIAL TREATMENT PROCEDURES

All treatment staff receive training in how to prevent violent behavior among the children. There are times, however, that violence cannot be prevented and must be de-escalated in a manner to prevent harm to all residents and staff. When necessary to respond to violence toward self or others, two types of behavior management interventions may be necessary, therapeutic holds and removing the child from the proximity of other children. Consistent with Federal and State regulations, both of the above interventions are to be appropriately documented in the child's file. If these interventions are necessary, the following procedures are to be followed in their use.

REMOVING THE CHILD FROM THE MILIEU

The agency does not believe in isolating young children. Traumatized children need the reassuring presence of a trusted adult when they lose the ability to cope with stress. Isolating young children can make the problem worse. Children have the right to be a part of the program and full participants in all aspects of the environment. However, when aggressive emotional externalizations place the child's safety and others' safety directly at risk, they may need special supervision to ensure everyone's protection. At such times, children may need to be removed from the immediate proximity of other children but are to always be with staff. If the child is not with the other children due to safety reasons, he/she/they are to be in the presence of staff. Calming times or using Cognitive Restructuring in the general area of other children may also be used. Children are not to be placed alone, even in his/her/their room, for more than 15 minutes unless they request the opportunity to be alone.

If the staff member believes that safety requires more than a short period away from other children, the program director must authorize the intervention, and this is only to continue, if necessary, in the opinion of the director. If the removal lasts more than 15 minutes, it is to receive authorization from the program director. If the removal meets the thresholds mentioned earlier, the child's psychiatrist and clinical team are to convene on the issue. Additionally, any time a child is removed from the milieu as described, the intervention is to be documented in the treatment log and staff log, and the information is also to be referred to the Quality Assurance Committee.

THERAPEUTIC CONTAINMENT HOLDS

In essence, the only reason to physically restrict a child's movements is to ensure the safety of the child and others by preventing a child from violence that could cause injury. Containment holds are serious interventions and are appropriate only 1) when clinically indicated, 2) when part of the child's treatment plan, and 3) after less restrictive alternatives have been tried and were unsuccessful. If the safety of all concerned requires a therapeutic hold, such a hold is to be performed only by staff persons who have completed the required Agency training, in accordance with CPI standards and consistent with the restraint procedures outlined in this policy. Therapeutic holds are not to be used as punishment,

discipline, or as a convenience for the staff, which would eliminate the therapeutic aspect of the intervention. In the residential programs the following key practices are to be followed:

- ***Authorized order for special procedure.*** If a containment hold is required, an order from a licensed Agency representative will also be necessary (see details in Authorization Process).

- ***Thresholds & authorization.*** Various thresholds apply to physical interventions. A containment hold shall require a review and authorization by a licensed authorizer. If the hold lasts longer than the time authorized, it must be reauthorized. A hold is not to exceed sixty minutes in length for children under age 9 or one hundred and twenty minutes for child 9 and older. Typically holds last much less time than these limits.

- ***Number of staff.*** Shift leaders and any treatment staff can request assistance at any time. Teamwork is essential for effective interventions. Children are to be held by two staff unless there is an emergency situation where the intervention is performed by one person. In accordance with CPI standards, two-person holds are the expectation in violent situations. However, there may be situations, such as availability of staff or an immediate emergency, where two staff are not part of the hold. In such cases, the psychiatrist or state licensed authorizer is to be contacted immediately, to review the intervention.

- ***Continuous Well-Being Check.*** Children in a containment hold are physically and psychologically vulnerable. For this intervention to have therapeutic value, the child must experience safety and a genuine concern to his/her/their well-being. It is the responsibility of the staff to continually monitor the child during the process of the hold to ensure, the child is experiencing no pain as a result of the intervention, respiration is unrestricted, and the child is psychologically experiencing the hold as supportive containment to ensure safety. The child is to be monitored for all basic needs during holds, including but not limited to food, water, clothing, or access to bathroom facilities. Any physical or psychological concerns are to be reported to the hold authorizer performing the post-hold well-being check. The agency nurse is to be consulted in cases where there is any question as to the need for follow up medical care. Agency medical staff shall direct other Agency staff to seek immediate medical attention if there is a question of an injury that may need medical follow up.

- ***Case-by-case assessment & review.*** Interventions to prevent violence and injury must be individually assessed and implemented with caution and care. They should last only for the length of time necessary to have the child resume self-control. The individual child must also be taken into consideration, the past trauma, the severity of the symptoms, the seriousness of the child's behavior, and the anticipated response of the child. In addition, all interventions used by Agency staff are to be assessed for their need, for their effectiveness, and for their impact

on the individual child. Interventions that are either not effective or produce an adverse result on the child, either in physical or emotional ways, are to be discontinued. If there are concerns, the staff person is to bring the issue to the shift leader or program director as soon as possible.

AUTHORIZATION PROCESS

The first level of authorizing special treatment procedures rests with the child's parent/guardian. Because young clients of Jasper Mountain are minors, the parent/guardian is required to give the approval to the procedures outlined in the child's behavior management plan. Permission is obtained at admission and lasts until discharge, unless it is revoked. Parent/guardians who decline permission for special treatment procedures outlined in this policy can do so but this may hinder the ability of the Program to treat the child. All reasonable accommodations will be attempted, but if the child remains a danger to self and others and if permission is not granted to intervene to ensure safety, the result may be that the child is referred to another service.

Once permission is obtained from the parent/guardian, the State of Oregon specifies program staff who are allowed to authorize containment holds in a residential program. The shift leader will be informed of the authorizing staff person for each shift. This will be the psychiatrist or a State licensed professional among the Agency medical or clinical staff who have been approved by the Office of Addiction and Mental Health.

More specifically, staff who can give an order for a restraint have been licensed by the State of Oregon as a Psychiatrist, Psychologist, Licensed Marriage and Family Therapist, Licensed Professional Counselor, Licensed Social Worker, or Licensed Emergency Safety Intervention Specialist. These licensed staff are to be trained in the State and Federal requirements of restraint. Each authorizer is to be provided with a copy of State and Federal rules and is to attest that they are familiar with each. These licensed professionals are to have current CPR and First Aid certification. Updates and further training are to be provided to authorizers. The psychiatrist or State licensed designee can provide an order to contain the child if the situation fits the requirement of a safety concern for the child or others around the child. If the psychiatrist is available, they must provide the order.

OBTAINING AN ORDER FOR RESTRICTIVE BEHAVIORAL INTERVENTIONS

If the behavior of the child escalates to a concerning degree and de-escalation techniques are not successful, staff are to contact the Psychiatrist or the State Licensed Staff approved as emergency safety intervention specialists. Federal and State guidelines expect staff to contact the authorizing staff as soon as possible. The priority is to safely address the emergency caused by the behavior of the child. As soon as possible, however, one of the staff is to contact the authorizing staff. State guidelines also expect staff to immediately inform the authorizing staff when a one-person hold is necessary. Again, the emphasis must be on maintaining safety.

As stated above, staff are to contact the psychiatrist or licensed designee as soon as it is safe to do so, to receive a written or verbal order. This licensed designee is also to be available for

consultation during the intervention. The lead staff is authorized to receive the order. If this is not possible due to the emergency situation, another available CPI certified staff person may receive the order instead.

The order must include who ordered the hold, the date and time of the authorization, the specific intervention ordered and the maximum amount of time for the order. The order shall also indicate the time of authorization, the time the hold began and ended, and the time of the face-to-face well-being check by the authorizer. Holds of less than 10 minutes are expected. If the intervention needs to go beyond 10 minutes, the authorizing staff is to approve an extension in 5-minute increments. Approval must include information related to the continuing danger posed by the child's behavior and show that there are no concerning impacts on the child. The order for the hold can only be implemented for the duration of the emergency. Federal regulations restrict holds for any reason that exceed 2 hours when the child is age 9 or older and 1 hour for a child under 9 years old. The containment hold is to be as short as possible to resolve the emergency situation.

WELL-BEING CHECK BY HOLD AUTHORIZER

A face-to-face well-being check of the child is to be made by the licensed authorizer within 60 minutes of the initiation of the hold. This well-being check must include: the child's physical and psychological status, the resident's behavior, the appropriateness of the intervention, and any complications from the intervention. These aspects of the well-being check are to be attached to the incident report.

FACTORS TO CONSIDER

As a part of ensuring the wellbeing of the child who is at the receiving end of the intervention, several factors are to be considered, including the following:

- ***Physical status*:** First, the physical status of the child is to be reviewed. Are there any injuries that are either observable or not observable? This can be somewhat difficult, since the child who is emotionally externalizing may not always be a good source of accurate information. The child may not report an injury or more often they may claim to be badly injured. It is important that the authorizing staff do not adversely impact the intervention by giving a child excessive attention for serious acting-out behavior. The task is to ensure the child's physical status.

- ***Mental/emotional wellbeing*.** The mental and emotional wellbeing of the child must also be considered. Crisis situations are nearly always difficult for the child as well as the staff. It is important to have some knowledge of the child and be able to determine if there are any negative results from the situation that can be addressed. Frequently, a skilled staff person can deescalate a child's crisis in a way to gain therapeutic interactions with the child. When this is not possible, the child's wellbeing must be assured.

- ***Need for additional medical assessment*.** When assessing the physical and emotional wellbeing of the child, a determination is to be made whether any

additional medical assessment or treatment is appropriate. Medical staff of the Agency are always on call and are to be consulted when there is any question. Immediate medical attention is to be provided when there is concern that follow-up medical care may be needed. The well-being check is also to consider the child's behavior and any concerns that have come up as a result of the intervention.

- ***Basic needs.*** The authorizing staff is to ensure that the basic needs of the child are met. Interventions are not to prevent the child's access to food/water or use of the toilet. The most immediate issue is to ensure that the child's breathing is not hindered in any way.

- ***Length of intervention.*** Perhaps the final consideration for the authorizing staff is to consider the length of the intervention and whether it should continue or be terminated. Before this determination is made, it is important to consult with the staff who are performing the intervention. If it is the professional opinion of the authorizing staff that the intervention is to be discontinued, the staff are to follow this determination.

In addition to the responsibility of the hold authorizer to conduct a well-being check, it is the responsibility of the staff performing physical interventions to ensure the safety and well-being of the child during the intervention. Annual training will be provided to all hold authorizers covering the physical (respiration, hydration, potential injury), emotional (dissociation, triggering, trauma reactivity), and when medical assistance is indicated. Additional policies on physical interventions to meet the Federal Department of Health & Human Services (42 CFR Part 483 Subpart G), can be found in *Containment Holds*, above.

DEBRIEFING

There are three debriefing sessions that are to follow a containment hold. The staff involved are to debrief the situation with the child immediately after the incident. The staff need to ensure the debriefing is understandable to the child. This discussion is to include how future incidents can be prevented. The debriefing with the child is to be documented in the incident report including who was involved.

The involved staff are also to debrief with the authorizing staff. The supervisor or shift leader is also to debrief the intervention during the same shift. This debriefing is to include what caused the emergency, the emergency itself, what interventions were used, what methods were used to prevent the intervention, what could be done in the future to deescalate the situation, and if there was an injury to either the child, the staff, or to other children. The next day, the training staff will review the incident to see if further debriefing is needed.

These various debriefing sessions are designed to maximize the learning for the child and the staff involved and should include discussions of precipitating behavior, any need for modifying the behavioral management plan, and consider alternative steps that could be taken. The Agency trainer will consider the incident within 24 hours to see if further steps such as staff training are indicated. If an injury is received by a child during a special

treatment procedure, the involved staff are to have an additional debriefing with the program director.

The purpose of each of these steps is to ensure the correct and safe use of physical interventions and improve upon the ability of the staff to handle violent situations in the safest and most therapeutic way possible. Any recommended alterations in the child's treatment plan are to be forwarded to the therapist for the child.

Debriefing is also to occur with the staff or Agency treatment foster parent implementing the containment hold and those observing the intervention. The purpose is to not only determine the nature of the situation and whether the optimal steps were taken to ensure a safe and therapeutic intervention, but also to check on the condition of the staff including any distress that the intervention produced. Any needed assistance is to be provided to the individual. Suggestions are also to be included in the debriefing regarding steps that can be taken in the future to prevent, reduce, or improve the intervention.

DOCUMENTATION

Interventions in all Agency programs meet the standards of the Oregon Health Authority (OAR), which can be found in the Health Systems Division: Behavioral Health Services, Chapter 309, Division 32: Community Treatment and Support Services. All Agency interventions shall be documented in the child's file. This documentation is to include less restrictive methods attempted, the required authorization, length of the hold, precipitating events, presence of a threat of harm, assessment of any physical injury, and the response of the child. Further details regarding the required content of this report are outlined in *Incident Reports,* below.

After debriefing, the staff involved in the containment hold are to write an incident report before leaving the property. All required information is to be provided in the incident report and it is to be given to the Agency trainer for review. The report is then to be filed in the child's file and referred to the Quality Assurance Committee. All incident reports are reviewed by the Agency director.

In 2021, Senate Bill 710 was enacted to help protect children from injury during physical interventions. A physical intervention is defined as any action by which movements of another are restricted and is an act of care and control aimed at ensuring the safety of the youth and others.

According to Licensing Rule 413-215-0078 enacted 9/1/2021, each child in care receiving services from a child-caring agency must be given the following:

- Instruction regarding how a child in care may report suspected inappropriate use of restraint or involuntary seclusion.
- Assurance that the child in care will not experience retaliation for reporting suspected inappropriate uses of restraint or involuntary seclusion.
- The telephone number for the toll-free child abuse hotline described in ORS 417.805,

and the contact information for the program's licensing agency, and the child in care's caseworker, attorney, CASA, and DRO advocate.

The information must be provided by:

- The Department of Human Services, if the department placed the child in care in the child-caring agency.
- The Oregon Youth Authority, if the child in care has been committed to the custody of the authority.
- The child-caring agency for all other children in care.

Incident Reports **(See Appendix B)**

Events that occur during a shift that are of unusual interest or significance including, special treatment procedures, unusual events, reportable incidents, or disclosures of abuse are communicated to all relevant staff and members of the overall team. The format for reporting this information depends on the type of information involved.

The "Incident Report" format includes four different types of incidents:

1) Disclosures of abuse by children,
2) Physical interventions that meet the state definition of "personal restraint,"
3) Removal of the child from the milieu for fifteen minutes or more (meeting the state definition of "isolation"), and
4) "Reportable incidents" as defined by OAR

The staff involved in a containment hold (personal restraint) complete an Incident Report (IR) before leaving the shift. The order authorizing the containment hold is listed in the IR, as well as the date and time of the order. If the licensed authorizer was not the psychiatrist, the psychiatrist is notified promptly. The incident report also includes the results of the well-being check of the child including any concerns for physical or psychological well-being, child's behavior, appropriateness of the intervention, and/or any other complications. The IR addressed less restrictive interventions that were used and the outcome of the intervention and how the situation was resolved.

The parents or guardians of the child and the caseworker are notified of the containment hold as soon as possible or within one working day. This notification will generally be the IR, because it includes full details. The IR is sent to legal guardians within 24-hours business hours. The incident report documents the date, time, and person who notified the family.

After completing the incident report form, a shift leader or management staff person is to receive the incident report before the end of the shift on which the incident occurred. The designated staff will review the report for completeness, and any questions or concerns will come back to the staff who authored the report for clarification. The incident report is to include sufficient information to make the situation understandable to someone who was not present. This is to include the following:

- ☑ child involved
- ☑ staff involved
- ☑ date and time
- ☑ circumstances
- ☑ precipitating events
- ☑ the incident itself
- ☑ the result of the incident
- ☑ action taken
- ☑ authorization of the intervention if pertinent
- ☑ notification of psychiatrist, parents & caseworkers
- ☑ any injury
- ☑ length of containment hold
- ☑ number of staff involved
- ☑ documentation of debriefing
- ☑ supervisor comments
- ☑ any suggested follow up

The report is placed in an Agency incident report file, as well as in the child's file. Injuries, either to a resident or staff member are documented on the Agency "Injury Report Form." These can be found at all program sites and in the business office.

Reportable incidents that are to be provided to regulatory authority are defined as: "a serious incident involving an individual in an Intensive Treatment Services (ITS) program that must be reported in writing to the Division within 24 hours of the incident, including, but not limited to, serious injury or illness, act of physical aggression that results in injury, suspected abuse or neglect, involvement of law enforcement or emergency services, or any other serious incident that presents a risk to health and safety," as defined by the OAR.

Other events of interest that may not rise to a reportable incident could include:

- Sexual behavior
- Very unusual behavior by a resident
- Self-destructive behavior/suicide themes
- Threats of false accusations of abuse against a staff member
- Significant information not previously obtained

Details on the above are to be recorded both in the progress notes in the logging on children and in the staff log. The reason to record this information in both places is because different staff will be reading one or the other source.

INJURIES TO RESIDENTS DURING TREATMENT PROCEDURES & CRITICAL INCIDENT REPORTING PROCEDURE

Responding to injuries during special treatment procedures is the same as injuries at any time in the program. Whether a resident or staff member is injured, first aid procedures are to be followed per first aid training. If the necessity arises that a child's condition could best be treated in a hospital setting, McKenzie-Willamette Hospital is to be utilized. In a serious situation, staff are to call 911 and request an ambulance and medical staff will determine the need for hospitalization. In less serious cases, the lead staff is to consult with either the program director or the staff nurse to determine the need for treatment at the hospital, this includes medical problems that come up during the night. If the child is treated at the

Hospital, only information approved by Oregon Law shall be provided to treating medical staff. This information shall include any medical history of the child needed to treat the medical condition requiring treatment at the hospital. Other mental health information that is not pertinent to the child's medical condition is not disclosed. When the child leaves the hospital, staff are to obtain written discharge instructions that include any need for medication or follow up.

If an injury is received by a child during a special treatment procedure, the involved staff are to have an additional debriefing with the program director. Consistent with Agency policy, all injuries to either a child or staff are to be documented immediately or within the shift when they take place. After the injury is medically treated, the involved staff are to discuss a plan to prevent further injury with the program director.

REPORTING OF CRITICAL INCIDENTS

In the event of an Oregon defined "Reportable Incident," the program director is to contact DHS Licensing and the liaison with the regulatory agency with full information on the situation within 24 hours or before the end of the next business day, whichever is sooner. The protection and advocacy organization (DRO) is also to be contacted if a serious injury occurs in the context of a personal restraint. The program director is to provide to these organizations the name of the program, the name of the resident, details of the situation, the address, phone and contact information with the program. A "reportable incident" requiring notification is a serious incident that presents a risk to health and safety including: "serious injury or illness, act of physical aggression that results in injury, suspected abuse or neglect, involvement of law enforcement or emergency services." Injuries that are of a minor nature and can be resolved using routine first aid are not deemed serious. If a child develops an injury of an unknown origin, the program director is to be consulted along with the staff nurse and the cause of the injury is to be investigated. The program director will determine if the injury meets the criteria of a reportable incident. All incidents reported to the State (Licensing & Regulatory Agencies, 500 Summer Street NE Salem, OR 97301) and State designated protection and advocacy organization (DRO, 620 SW Fifth Avenue, Suite 500 Portland, OR 97204), and are to be documented both in an incident report file and in the clinical file of the child involved.

If a serious injury occurs to a child by any means in the program, the program director shall ensure that the parents or legal guardians of the child are contacted with detailed information with 24 hours. Parents are to receive sufficient information to understand the extent of the injury, the cause of the injury, and the steps taken by staff to obtain treatment for the child. Notification of the family is to be documented in the child's clinical file.

ENHANCED SUPERVISION TO PREVENT SELF-HARM

Jasper Mountain personnel takes all levels of self-harm seriously including minor and major issues including suicidal ideation, threats, and actions. Children entering any of our programs are assessed to determine what their treatment needs are, what their history is, and ways that have been successful/unsuccessful in the past to prevent them from causing harm to themselves or others. We have children who may come to us in a crisis without

background information as well as other children who have serious histories of acting-out, therefore Jasper Mountain practices universal precautions in our daily routines and the milieu to monitor children for signs of distress or potential self-harm.

Upon intake, Agency personnel assess a child's risk of self-harm and suicidal ideation, and then communicates to other agency personnel the level of close physical proximity and supervision necessary to maintain the child's safety. Personnel are trained to observe a range of emotions and behaviors and to be in close physical proximity and provide more overt supervision for children who display signs of increased erratic and unpredictable behavior. Personnel are initially trained during their agency orientation, and then re-trained annually, as to emergency protocols in the event a child has a life-endangering incident. This includes utilizing the Employee Emergency Manual (located by every phone) to contact emergency personnel (911) if the situation warrants, then contact the program director or their designee (listed on the Emergency Manual or communicated in the personnel logbook), and the agency nurse. Similar protocols are followed day and night. All personnel are trained in First Aid and CPR, with annual renewals, and the personnel present with the child make the initial determination as to the seriousness of the attempt. Further consultation and direction as to treatment will occur from 911 responders, program director, agency nurse, personnel's supervisor, child's Tterapist, the guardian, and/or other designated support personnel depending upon the seriousness of the incident. With universal precautions we have a good track record of preventing the ability of children to successfully act on threats of self-harm, whether the threats were to gain extra attention or were serious plans to attempt to end their life.

When personnel are aware of specific threats by a child regarding self-harm, personnel are to use their physical position to help prevent the child from not only following through on self-harm but even believing it is possible. The use of physical support works in conjunction with emotional and behavioral counseling and modeling for children to identify healthier coping strategies to manage overwhelming feelings. In the event of an attempt at serious self-harm, the child's guardian and therapist are notified as soon as possible once any life threatening or serious medical needs of the child are addressed. In situations that involve lower risk and minor injury, the nurse, program director, guardian, and therapist are notified to assess if the child needs to see a doctor to treat the injury and to communicate next steps to care for the child's emotional and physical needs. For serious attempts/incidents, once the child is stabilized, personnel will document in an Incident Report (IR) the course of the incident, steps taken to maintain the child's safety, what communication occurred and with whom, how the situation resolved (medical attention necessary, supervision plan, etc.) and with who and how follow-up will occur with the child and their guardian. As has been mentioned before, Jasper Mountain personnel are trained to provide the highest level of supervision possible given the intense behaviors children entering the program display. Universal precautions are utilized regularly to monitor each child's overall well-being and safety. Those children displaying increased levels of risk of unsafe behavior will be in closer physical proximity to adults and provided reduced access to materials that they could use to harm themselves or others.

Personnel communication in written and verbal form, in collaboration with the child's therapeutic team, provides continuous monitoring for a child with self-harm or suicidal concerns 24 hours a day until the risk is reduced. The program director, in collaboration with the child's therapist and the therapeutic personnel, will determine when a child requires closer physical proximity to adults and support to prevent suicidal behaviors, with this same collaboration occurring to identify when it is safe to reduce this increased support. Children's comments on suicidal ideation or behaviors involving self-harm are to be documented in their daily progress notes.

Children's safety during the bedtime hours must be a specific focus. The daytime and nighttime personnel will assess the bedroom of a child at risk for self-harm or suicidal ideation and will remove any concerning items, such as items with laces or cords, non-food items that could be ingested, items such as staples that could be used to cut themselves, etc. These precautions take place nightly prior to the child entering their room for bed. When a child has been identified as at-risk for self-harm during the hours between bedtime and wake up, the night personnel will document in the night logbook consistent checks at least every fifteen minutes through the night that the child on "suicide watch" is safe and sound in their bed. Our supervision technology with laser monitoring will notify night personnel of any out of bed situations for the child. Extra floor-based alarms can also be utilized to ensure a child actively seeking self-harm cannot be successful. Night personnel can also position themselves near the doorway of a child until the child is asleep. This provides a preventive step to self-harm and emotional reassurance to the child.

During the day, all children are to be both within visual and auditory supervision as a precaution to any attempts at self-harm. Personnel should be aware of any children who pose a particular risk and should take additional precautions such as, monitoring the child's ability to cause harm during an activity such as on a hike, ensuring a child cannot use a bicycle to reach the highway, and staying a step ahead of the child to consider any possible environmental threat or means to cause harm. Children who present a serious risk of self-harm are not to be taken off property due to the vulnerability in transportation or less secure settings where harm is a possibility. Children who show consistent risk for suicidal ideation and self-harm will have treatment goals and their behavioral point sheet reflect a focus on maintaining safe behaviors, with documentation and review over time as to progress. Those children identified at ongoing risk for self-harm or suicidality and who are discharging from the program, will have their next professional care team informed of the level of supervision and diligence necessary to maintain their safety.

Any child who poses a risk severe enough that the Agency's environment cannot maintain their safety, will be considered for a referral to a higher level of secure care, such as a sub-acute or hospital placement, in order to maintain the child's well-being. Thoughts of self-harm cannot be identified in all children, so the population of Jasper Mountain requires continual vigilance and supervision for all children as if they pose a risk of self-harm.

INTERVENTION TRAINING

Every component of this section of agency policies and procedures will require initial as well as on-going training. Employees will receive initial training in a wide variety of areas

including crisis intervention, documentation, building upon strengths, first aid, among others. The organization has requirements concerning updates on trainings in each area. Individual employees have a section of annual performance reviews that address compliance with required training both initial and ongoing. All staff are to stay current in the areas required by their respective roles. Trainers are charged with identifying staff who may not be competent in a specific area of training and may need remedial instruction. Any such issues are to be communicated to both the employee's supervisor and a program director for follow up. A detailed list of training expectations for each position can be obtained from the Training Coordinator, who oversees the training component of the organization. There will be assigned trainers in each area of the organization's training curriculum.

APPENDICES

APPENDIX A: Jasper Mountain Policies & Procedures Manual, 2. A. 5. 01-07.

APPENDIX B: Jasper Mountain Policies & Procedures Manual, 2. A. 6. 01-03.