

Controlling Behavior or Reclaiming Youth?

Creating a Behavior Management System Based on the Circle of Courage

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Many programs serving troubled youth struggle with behavior management systems that are not focused on treatment and do not provide the skills needed by youth to transition back to their communities. Looking outside the boundaries of traditional point and level systems can be one way to eliminate these problems. This article describes the authors' experience in designing reclaiming environments that, ultimately, would replace their programs' existing point and level systems.

"If it's not broken, don't fix it!" Are these really words to live by? Can complacency really be better than being proactive and implementing changes in order to make things better, not just because something no longer works? As discovered by the characters (Sniff, Scurry, Hem, and Haw) in the book *Who Moved My Cheese?* (Johnson, 1998), change is a good and sometimes very necessary thing. That need, to seek out and make changes for our own betterment, is a part of our humanness. A recent pop-culture example can be seen in the movie *Star Trek: Nemesis* (Berman & Baird, 2002). As Captain Jean-Luc Picard explains to his clone, part of being a human is "the potential to make yourself a better man...to make yourself more than you are." That may be true, but do we have the same human desire to seek out and make changes for the betterment of the treatment programs we run and for the clients we serve? Many times the day-to-day responsibilities of running a residential program (paperwork, financial constraints, staffing issues, regulatory audits, etc.) keep us from seeing that change is needed, unless something is indeed broken.

Starting the Journey

Three years ago, we were faced with this challenge: "How do we unify the program structures of three

residential treatment programs, each serving adolescents with similar behaviors and treatment needs but using different behavior management systems?" During our initial planning sessions, we made some eye-opening admissions:

1. We had more residents with more acute treatment needs, who were not being successful in our programs;
2. When a resident transferred from one of our programs to another, any progress they had made in their treatment was frequently lost; and
3. It was common for a resident to be successful within a program's milieu but fail when he or she had to transition back to a community that lacked similar structures and supports.

Did this surprise us? No, of course not. We were stubbornly continuing to do what we had always done because that was the way it had always been done. Does the definition of insanity come to mind? At that point, we decided that simply developing unified program structures was not the right path to take. How did we find the right path? We took a bold, revolutionary step and looked to the needs of the youth in our programs to be our guides. If helping them with their journey back to their own communities was our focus, then surely we were on the

right path. As we took this new path, our journey led us to the creation of a new behavior management system based on Native American child-rearing philosophies found in the book *Reclaiming Youth at Risk: Our Hope for the Future* (Brendtro, Brokenleg, & Van Bockern, 1990/2002). So, like Sniff and Scurry, we had begun our search to find our “new sources of cheese” (Johnson, 1998).

What Path Did We Choose?

The first decision we made on our journey was to agree on a structure that would help children and youth bridge the gap between being successful in a treatment program and being successful at home. This meant we had to step “outside of our box” by abandoning and replacing the systems we had always used, namely our point and level system. Using Circle of Courage and the four dimensions of a reclaiming environment, Belonging, Mastery, Independence, and Generosity (Brendtro et al. 1990/2002), seemed to be the most appropriate choice. Other major structural changes that we made included replacing standardized behavior expectations with individualized treatment goals; using report sheets, instead of point sheets, to track these goals; and eliminating the process of giving and taking points.

As we saw it, our old point and level system, based on a “cookie cutter” set of behavior expectations for all residents, had several problems. First, the behavior expectations were not individualized. All residents, admitted to a program, were “graded” on the same set of expectations regardless of their individual needs and abilities. Some residents routinely got all of their points for certain expectations, which they found to be too easy. While others continually lost points for the same expectations, which they had little chance of meeting. Secondly, these behavior expectations rarely reflected the treatment goals specified in their Individual Treatment Plan (ITP). It was entirely possible for a resident to get all of his or her points each day and not be working towards meeting the treatment goals at all.

As anyone using them would probably attest, points and point sheets presented their own set of problems, one being that residents rarely view points as something they can earn. Their experience has taught them that points were these “things” that staff either gave to them or took from them. Then

there was the issue of the countless situations between residents and staff that began with the words, “Why did you take those points away from me?” These situations invariably led to a resident’s getting mad and tearing up the point sheet or losing so many points that there was little chance left of being able to “make his or her day.”

Another common problem was that the residents tended to focus on the number of points they had, instead of focusing on their behavior or meeting their ITP goals. Our solution was to focus on whether or not our residents were meeting their ITP goals on a daily basis. We did this by first developing a report sheet to track their progress. These sheets were divided into three sections (Days, Evenings, and Nights). Each section was then divided into hourly blocks and included space for up to five treatment or behavior goals. Treatment goals were taken directly from each resident’s ITP, while the behavior goals were based on those problem behaviors (cursing, yelling, not cleaning their room, etc.) which were important for the resident to improve upon, but were not necessarily treatment related. On each sheet, staff simply had to circle a “Y” if a goal was met for that hour or an “N” if it was not met. If an “N” was circled, the staff had to document, in the space provided, how or why that goal was not met. This process not only eliminated many of the problems we had encountered with points and point sheets but also enhanced communication between the staff and the residents. Staff no longer had to face being asked the question, “Why did you take that point from me?” Instead, they were able to have what Nicholas Hobbs (1982/1994) calls a “teachable moment.”

What Did Their Journey Look Like?

Since we were using the Circle of Courage as a structure, we decided that all residents in the program would fall into one of the four dimensions. They would move from one phase to the next by completing specific goals and activities for each, and thus work their way through the system. All new residents started with Belonging, based on the idea that in order to be successful, either in treatment or in life, you have to feel like you belong. Brendtro et al. (1990) wrote that belonging is not simply a result of membership in a group, instead “the ultimate test of kinship was behavior, not blood: you belonged if

you acted like you belonged” (p. 46). Because the activities or criteria for completing each area needed to exemplify the philosophy of that particular point, the criteria for achieving Belonging activities were designed to help demonstrate the understanding of what it means to belong to a group or a “family.” One example of these Belonging activities was for each resident to write an autobiography. Residents were to include basic information about themselves and their families, their strengths and weaknesses, what the circumstances were that led to their placement in custody (or in our program), and the things they needed to work on in order to successfully return either to their home or to the community. Once a resident had accomplished all the activities or criteria required for completing one dimension, he or she would then move to the next.

Treatment goals on report sheets were not the only individualized element of this system. The pace at which residents moved through the system was also based on their ability and motivation. A moderately motivated resident might take six months to move from one phase to another, while a more highly motivated resident might take only three. Their ability to progress at their own pace and understand the philosophies of the program was far more important than rushing through on schedule and being unprepared to continue their journey. Another way the system was individualized was that if one of the criteria for completing a phase was not developmentally appropriate for a resident, it could be modified. An example might be a 16-year-old mildly, mentally retarded male with a limited ability to read and write. Instead of having to write his autobiography, he could have the choice of either doing it verbally or dictating the information to a staff member who could put in writing.

All of these changes meant that each resident had more responsibility for his or her individual treatment. To help them with this, treatment teams were developed. The treatment team consisted of the people who had the greatest responsibility for a resident’s ITP. The treatment team would, ideally, consist of the child or adolescent, along with their therapist, case manager, one-on-one staff member, and the youth’s parents or guardians. This team would be responsible for making any needed changes based on developmental ability, providing encouragement to continue “working the program” and ensuring that all the requirements for advancing

to the next area had been completed. This team would serve as not only a substitute family, but also as a coach and cheering squad.

We wanted each aspect of this new system to be positive or to emphasize accomplishment. A common element of point and level systems that goes against a sense of accomplishment is a “level drop.” VanderVen (2000) states that losing level privileges can often increase inappropriate or defiant behaviors. In our experience, a resident faced with the eventuality of “losing their level” can also lose their motivation to continue working the program and may abandon all desire to work on their treatment. Adolescents often see level drops as punishments and the loss of “level privileges” as one more thing staff have taken from them. Both do little in helping an adolescent in residential care on his or her journey back to the community. Remember how you felt when you were promoted each year in school to the



“A State of Urgency or Taking Flight,”
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next grade? You were promoted once you had successfully completed the required curriculum for that grade, and once you had been promoted there was nothing you could do to get moved back. We wanted the residents to feel that way when they completed one dimension and moved to another. After discussing, at length, the pros and cons of dropping a resident's level we finally decided against it. Anytime a proposed change brought about controversy, we forced ourselves to take a step back and decide which alternative was better for the residents' success in the program and in their journey back to the community. In other words, we looked to the importance of which alternative was more "normative" for them, not which gave us more control over their behavior. Looking at controversial changes in this way, how could we go wrong?

You are probably wondering what kinds of consequences the residents received for acting out behaviors. Instead of level drops, we instituted a process for freezing privileges. When a resident engaged in certain behaviors (e.g., attempts at running, major property damage, physical assaults, school suspension, etc.) any privileges they had, based on their status, were frozen. Instead of losing privileges completely, residents would lose the ability to partake in the privilege for either a specific amount of time (one day, one week, etc.) or until they had made amends for their behavior. If residents were suspended from school, their privileges would be frozen only until they were able to return to school. For property damage, their privileges could be reinstated after they made arrangements to pay for any needed repairs or helped repair the damage themselves. Knowing that the "loss" of their privileges was only temporary made it easier for the residents to deal with the consequences of their behavior and make reparations for it without the loss of motivation and threat of reprisal that often accompanied the dreaded level drop.

What Did Our Journey Teach Us?

As our journey continued from the planning stage through training staff into implementing the new system, we found ourselves learning many things. We not only learned from implementing and overseeing the new system, we also learned from staff feedback, and maybe, most importantly, we learned from our residents.

Our first lesson involved coordinating with our residential school administration. Instead of waiting until we had the new system in place to explain it to them, involving the administration during the planning phase would have been much more beneficial. Some of their suggestions were better than the plans we had made. For example, we had planned on getting information on behavior and grades from each resident's homeroom teacher. The administration suggested that they have weekly meetings with the staff of the residential center, thus giving a more complete picture of the residents' activities at school. Another lesson we learned was that when the staff (not just the therapists) and the residents are focusing on treatment goals instead of on arbitrary behavior expectations, the program truly becomes a treatment program instead of just a behavior program. We also learned that we could prove what we were accomplishing with the residents to the juvenile court system and to the state's child welfare workers. This was simply due to our no longer advancing residents based on, sometimes, subjective and/or arbitrary judgments. The advancements were now more concrete, with residents having to complete specific criteria as well as to show improvement in the frequency with which they were meeting their treatment goals in order to advance within the system.

The most important thing that we learned from the staff was that the new program made them feel like a valued part of the "treatment team" instead of just being a front-line staff member. Although they realized that this was no longer a "no-brainer" system, they enjoyed having to know more about each resident's treatment issues and making decisions based on the ITP. Staff also enjoyed spending better "quality time" with the residents because everyone was working together as a team with less of their time being spent trying to force uncooperative residents into compliance. Together we found that staff were, in a sense, working harder because they had to find and use more creative ways to solve problems. What this meant for us as program administrators and staff trainers was that the staff had a greater need for more intensive and creative training. They learned more about decoding behaviors and the Conflict Cycle that Mary Wood and Nicholas Long (1991) explain in their book, *Life Space Intervention: Talking with Children and Youth in Crisis*. They also learned how concepts like "private logic" and the loss of "family privilege" can affect adolescents and

their behavior (Seita & Brendtro, 2005). Using pop-culture examples, such as movies, (e.g., *Good Will Hunting* and *The Breakfast Club*) as training tools helped make training sessions more informal and more effective.

While we were not surprised to learn things about the new system from the residents, we were surprised to learn some of the things they taught us. We could see, almost immediately after implementation began, that the residents “got it” before the staff. We attribute this to control. Our old system was so expressly focused on external control that the residents often felt powerless to make their own decisions. The new system shifted much of this control to the residents themselves. Many residents who failed to succeed in the old system seemed to blossom in the new. They could see that the purpose of the program (and staff) was to show them that taking the right path and working on their treatment issues would only lead to bigger and better things. They were not being forced to work on their treatment because “that is what they had to do.”

Some of the staff had trouble getting it because they were unable to perceive this change as anything other than giving up the control needed to maintain order. With this single minded view, staff failed to see that encouraging residents’ internal locus of control meant helping them gain independence which could only lead to maintaining a sense of order without the struggles they had encountered previously. We also learned that an adolescent who had been conditioned to using a point sheet had to adjust to using something else. Once they made that adjustment, they could see that blame could no longer be placed on others (for their behavior) and that the responsibility for meeting (or not meeting) their treatment goals fell squarely on them. They understood that report sheets were more objective (showed a more accurate picture of their behavior) than point sheets and were directly related to their ITP. This connection clearly showed them how their choices affected not only their treatment but also how much longer it would take for them to return to the community.

Summary

How can you unify the program structures of different treatment programs that serve similar kinds of clients but use different behavior management sys-

tems? We are convinced that the answer is easy. First, use the book *Reclaiming Youth at Risk: Our Hope for the Future* (Brendtro, et al. 1990/2002) and the philosophies of the Circle of Courage as a road map to create one brand-new program for all of them to use. Second, keep in mind that the clients are the most important factor when discussing changes. Although programming needs to be “user friendly” for staff, for the clients the quality of the programming is vital to their treatment and, in many cases, their futures. Last, but most certainly not least, do not be afraid to think outside of the box and forget about the way you have always done things. As a result of our journey, we were able to create a behavior management system that seeks to reclaim troubled youth instead of trying to control their behaviors.

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