The use of Safe Physical Management and Time-out in Parent Child Interaction Therapy in Pennsylvania
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The Office of Mental Health and Substance Abuse Services (OMHSAS) is committed to the absence of the use of coercive techniques in the provision of treatment services to children and youth. In Spring of 2011, OMHSAS licensure staff identified several concerns about potential coercive techniques in Parent Child Interaction Therapy. Stan Mrozowski, Director of the OMHSAS Children's Bureau worked with Amy Herschell to prepare a position paper on the safe physical management and time-out practice in PCIT. Dr. Herschell is the lead trainer for PCIT in Pennsylvania and has been serving as the central point of contact for the effort supported by several Foundations, as well as OMHSAS and OCDEL, to expand PCIT throughout the Commonwealth. This position paper will serve as the basis for the use of time-out and safe physical management by PCIT programs in the Commonwealth.

Background :

- There is strong evidence, including longitudinal studies, that participation in evidence-based treatments can help parents change the developmental trajectory of their young, noncompliant child (e.g., Greenburg, Speltz, & DeKlyen, 1993). Clinically-significant behavior problems in young children will remain and evolve into even more difficult behavior unless parents are able to help the child shift onto a more developmentally appropriate trajectory through participation in early interventions. Early interventions, like PCIT, save the personal and family consequences as well as societal costs associated with behavioral health concerns, like disruptive behavior disorders, that begin in early childhood and continue across the lifespan.
- There are over 30 years of clinical experience and research studies, independent of the PCIT literature, specifically on use of time-out procedures with young children. This rich literature provides information on specific procedures and approaches that are most effective (see Everett, Hupp, & Olmi, 2010; Morawska, & Sanders, 2011 for recent reviews).
- The time-out procedure within PCIT is not unique to PCIT. Similar time-out procedures are used in other evidence-based parenting programs that target behavior problems in young children. Other programs with similar content include Triple P Positive Parenting Program (Sanders, 2008), the Incredible Years (Webster-Stratton, 1998), and Parent Management Training from the Oregon Social Learning Center (Patterson, 2005).
- The use of time-out by parents of preschool children is supported by the American Academy of Pediatrics and the best practice guidelines for the management of conduct problems.
- Time-out within PCIT is not used in isolation. It is only used in the context of a much larger set of strategies that include building a warm, supportive relationship between the parent and the child, using positive reinforcement for behavior, and managing misbehavior with proactive, positive strategies.

Proposed Response to Concerns

1) <u>Concern:</u> The fact that an agency has a time out room that can be locked (or the parents can hold the door shut).
    - <u>Response to locks:</u> Locked doors are not permitted. All clinicians with whom Dr. Herschell has contact (those in Allegheny County, those funded by the Heinz Endowment, and those funded by Southwestern Behavioral Health Management, Inc) have been instructed to remove locks immediately.
    - <u>Response to parents holding the door:</u> This concern is about whether the parent can control when the child can leave the time-out area. If a child is allowed to come out of time-out on their own, the time-out will not be effective (e.g., Everett, Hupp, & Olmi, 2010; Morawska, & Sanders, 2011; Roberts, 1990) and actually may do more harm than good in that there likely will be an increased number of time-outs (Roberts, 1990) and they may not be as safe (e.g., the noncompliant, irritated young child may run at or away from the parent).
    - <u>There will be training for parents to learn how to safely, and in a non-traumatizing way, assure that the time-out procedure is followed.</u> There needs to be a way to ensure that it is the parent who is in control of when the time-out or time in the time-out space ends, rather than the child being in control of when the time-out or time in the time-out space ends.

2) Concern: That the PCIT staff apparently condone the use of a locked time out room for young children.
    - Response: There are 3 solutions to this problem that will correct it and ensure that it does not happen again:
        1. Having a clear set of written guidelines on what is and is not acceptable for a PCIT time-out procedure in Pennsylvania. These guidelines will include specifications around the time-out space (e.g., no locks; use of a barrier method rather than a time-out room).
        2. Training or re-training will occur with each clinician who has participated in any PCIT training so that each person understands what is and is not acceptable for PCIT time-out procedures in Pennsylvania. This training should also occur with agency administrators and supervisors. Dr. Herschell has been in communication with clinicians and administrators about these issues.
        3. Ensuing consistency across trainers. We currently have groups trained by three trainers (Robin Gurwitz - Ohio, Amy Herschell – Pennsylvania, & Cheryl McNeil – West Virginia). Amy Herschell and Cheryl McNeil have done trainings together. In the near future, two additional trainers (Rhea Chase – North Carolina & Reesa Donnelly – Florida) likely will initiate training with a new group in collaboration with Amy Herschell. Given differences in state policies, we will work to ensure that all PCIT trainers (especially those from out-of-state) are knowledgeable about and are training clinicians in Pennsylvania standards.

3) Concern: That the book on PCIT seems to condone use of seclusion and punishment.
    - Response: Clearly some of the language within the PCIT book could be improved to reflect current terms within the larger mental health field. It seems like this is an example of two things: 1) carry-over of out-dated language, and 2) the semantic divide that sometimes occurs between academic and real-world settings. For example, in the original parent management training literature, the term "punishment" is frequently used (e.g., "Time out: Punishment for little people" – from Patterson's 1976 Living with Children: New Methods for Parents and Teachers). Given that new or evolved treatments, like PCIT, were developed from the same literature, carry-over of outdated terms likely has occurred. Within behavior analysis and child clinical psychology the term punishment is not synonymous with punitive. Instead, the term punishment is actually meant to be neutral.

        "Punishment is often thought of as doing something unpleasant to someone, because he or she did something that you didn't like. To behaviorists, however, punishment is a highly technical term. A punisher is an even that (1) follows a response and (2) decreases the frequency of that response. It is, therefore, exactly the opposite of a reinforcer, which follows a response and increases the frequency of the response. Because of the behavioral definition of punishment, it is possible for an unpleasant event not to be a punisher, and it is possible for a pleasant event to be a punisher." (taken from Miller, 1976, p. 253)
    - Similarly, time-out in behavior analysis and child clinical psychology is really meant to stand for "time-out from positive reinforcement," which by definition means that time-out is not completed in isolation. It is part of a larger strategy that includes a warm, positive environment that is considered "time-in."
    - This does not mean that seclusion and punishment should be condoned or that this language is acceptable.

4) Concern: The belief that having a parent physically manage the child might be restraint.
    - Response: In PCIT a child is first verbally told to walk to the time-out chair. If the child is noncompliant with that request, the parent is then asked to guide the preschool–aged child to time-out. Often times, a parent's first reaction is to take the child by the hand or to pick the child up facing the parent. In PCIT, parents are instead coached to pick up the child from behind (to decrease the risk of injury and negative attention) and take the child to time-out. The time-out chair is in the playroom and is typically a few steps away from the parent and child so taking a child to time-out, even if the child is carried, typically takes a few seconds. Once on the chair, the parent immediately releases the child. The same is true for moving the child to the time-out space. Parents are instructed to safely carry the child to the time-out space, which is a few steps away. Once in the time-out space, the child is immediately released.

- This is meant to be analogous to the many times a parent has to physically carry or move a preschool-aged child. It is not meant to be a hold that is restrictive or long in duration.

5) Concern: That we need a clear definition of time out.
   - Response: The PCIT Time-out procedures are consistent with the definition of time-out in Residential facilities (§23.204) with one exception, the statement that " A child in time out may never be physically prevented from leaving the area where the time out is taking place." Research on the use of time out as a clinical intervention has indicated that if a child is allowed to come out of the time-out on his/her own, the time-out will not be effective (e.g., Everett, Hupp, & Olmi, 2010; Morawska, & Sanders, 2011; Roberts, 1990) and actually may do more harm than good in that there likely will be an increased number of time-outs (Roberts, 1990) and they may not be as safe (e.g., the noncompliant, irritated young child may run at or away from the parent).

6) Concern: Questions about what is being taught in regard to safe physical management and the use of time out.
   - Response: Similar to Concern #2, this will be addressed by: 1) having a clear set of written guidelines on what is and is not acceptable for the PCIT time-out procedures in Pennsylvania, 2) Training or re-training each clinician who has participated in any PCIT training so that each person understands what is and is not acceptable for PCIT time-out procedures in Pennsylvania, and 3) Ensuing consistency across trainers.

7) Concern: Whether the screening process addresses parents who are not appropriate for PCIT (perhaps because of sexual abuse).
   - Response: This is addressed within PCIT in two primary ways. First, PCIT clinicians must be masters' level and licensed. This level of credentials is applied because: 1) PCIT is a therapy, not just a "training program," and 2) clinicians with these credentials should be trained in assessment and treatment outside of PCIT meaning that they should be clinically savvy and skillful with important clinical topics (e.g., assessment of trauma) outside of PCIT. Second, there is a screening process to determine if families are appropriate for PCIT. The screening process, at a minimum, includes completion of three standardized self-report measures (Eyberg Child Behavior Inventory, Child Behavior Checklist, Parenting Stress Index), three standardized behavior observations scenarios (coded with the Dyadic Parent Child Interaction Coding System), and an in depth clinical interview. The clinical interview includes question about the family history (sample questions include: "have the child's caregivers had any of the following – learning problems, behavior problems, emotional problems, medical problems, experience with counseling? Have you experienced domestic violence? If yes, in which relationships, if yes, was the child exposed to violence?). Also, if clinicians are concerned about caregiver mental health, they are encouraged to do additional assessment in order to determine if caregivers' are appropriate for inclusion in PCIT.
   - The primary exclusion criteria for parents typically are active substance abuse, domestic violence, or psychopathology that would inhibit the parents' ability to participate in PCIT (e.g., active auditory hallucinations; severe personality disorder). Also, for parents who are not living with their child (e.g., those involved in the child welfare system) we wait to initiate PCIT until reunification seems highly likely which is operationalized as the parent having three or more visits per week with their child.

References

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