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National Definitions and Data Collection for Residential Care Facilities' Use of Restraint and Seclusion

By Lloyd Bullard

The Child Welfare League of America's (CWLA) National Advisory Committee on Residential Services recommended that CWLA develop a set of uniform definitions related to restraint and seclusion and a list of primary and secondary data points to be used in data collection.

The Committee viewed the lack of uniformity in definitions and data elements as barriers to data collection, information sharing, benchmarking, and advancing efforts to reduce and eventually eliminate restraint and seclusion. By instituting consistent definitions and data points, children's residential facilities, jurisdictions, and states will be able to access and analyze the data and compare their use of restraint and seclusion to other similar facilities locally and nationally.

In November 2003, CWLA held a National Definitions and Data Collection for Residential Facilities meeting in Miami, Florida. Attendees included CWLA members, providers from around the country, national accreditation organizations, behavior support and intervention training organizations, and other individuals and national organizations concerned with the use of restraint and seclusion. The result was a set of definitions concerning restraint and seclusion

and a list of primary and secondary elements for data collection.

Following the meeting, CWLA's National Advisory Committee on Residential Services, and attendees from the National Definitions and Data Collection for Residential Facilities, offered feedback, and the document was revised based on their comments.

The complete set of definitions and primary and secondary data points can be found on CWLA's Residential Group Care website at www.cwla.org/programs/groupcare. Providers, jurisdictions and states deciding to incorporate these definitions and data points into their policies, procedures, and practices may create their own network for information sharing, and benchmarking. In addition, these efforts could help the field reduce and eventually eliminate restraint and seclusion.

The League will continue to advocate and seek creative and diverse funding sources to establish a National Resource Center to collect and disseminate data and technical assistance for children's nonmedical residential facilities.

Lloyd Bullard is Project Director, Best Practices in Behavior Support and Intervention, CWLA.

INSIDE

Best Practices in Behavior Support and Intervention Assessment Instrument

A self-assessment tool developed to help agencies strengthen their behavior support and intervention policies, procedures, and practices.

—Page 2

The Sanctuary Model

The initial findings concerning a program designed to address the special treatment needs of youth with emotional and behavioral disturbances and histories of maltreatment. —Page 3

Are Point and Level Systems the Answer?

Do point and level systems bring about behavioral change at the expense of building meaningful relationships between staff and youth?

—Page 6

Point/Counterpoint

Is residential care a cost-effective service?

—Page 9

Shame and Anger

A closer look at the link between maltreatment and malcontent may yield better ways to manage and treat behavioral problems. —Page 13

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CWLA Publishes Best Practices in Behavior Support and Intervention Assessment Instrument

By Nupur Gupta

CWLA's new *Best Practices in Behavior Support and Intervention Assessment* was developed to help agencies strengthen their behavior support and intervention policies, procedures, and practices by conducting a thorough self-assessment. With the increasing awareness of risks posed by restraint and seclusion, agencies should consider high rates of restraint and seclusion evidence of treatment failure and thus strive to improve their policies and procedures so they can reduce the use of emergency physical interventions.

The Substance Abuse Mental Health Services Administration hopes to reduce and eventually eliminate the use of restraint and seclusion among institutional and community-based residential settings, and it has funded this project with that goal in mind.

Strong leadership is essential to eliminating the unnecessary use of restraint and seclusion, and self-assessment is the first step leaders must take. The assessment instrument covers five major areas agencies should review when assessing their behavior support and intervention policies and practices: ethical and legal framework, administration and leadership, continuum of intervention, medical issues, and professional development and support.

When conducting the assessment, agencies must keep in mind that careful evaluation includes closely reviewing agency documentation, as well as seeking information from a group of staff members, children, and stakeholders from each unit being evaluated.

Each section of the assessment provides several standards, along with supporting indicators, all of which must be carefully reviewed to accurately rate the agency's implementation of those policies. If an agency meets all of the indicators listed, the standard is consistently reflected, which implies all the practice standards

are consistently followed and only very minor or no improvements are needed.

If an agency misses only one or two of the practice indicators, that standard is partially reflected and requires improvement. If an agency misses three or more of the practice indicators, that standard is poorly reflected and requires significant improvement. If an agency meets none of the indicators, written policies and procedures for that standard are absent and clearly inadequate.

For example, under Ethical and Legal Framework, item number three states: The agency has a written statement outlining families' rights. Seven indicating factors follow, which include:

- Families have the right to receive written information, which the agency will translate if necessary, about the provider's policies and procedures.
- Families have the right to be involved in the assessment and service planning.
- Families have the right to be notified following any use of seclusion or restraint, suicide attempt, medical emergencies, or other seminal event.

The back of the assessment instrument contains an answer sheet to track ratings for all questions. The last part of the instrument includes an appendix detailing reference page numbers in the *CWLA Best Practice Guidelines for Behavior Management* corresponding to each standard and its supporting indicators.

With almost 50 questions to guide agencies in assessing the various policies and procedures an agency may have or need to revise, the assessment tool aims to provide agencies with the potential and right direction to reduce, and eventually eliminate, the use of restraint and seclusion. To learn more about the instrument or order a copy, visit www.cwla.org/programs/behavior/pubs.htm.

Nupur Gupta is a Program Assistant at CWLA.

Initial Findings of an Evaluation of a Trauma Recovery Framework in Residential Treatment

By Jeanne C. Rivard

This article briefly describes the initial findings of an evaluation of the Sanctuary Model (Bloom, 1997, 2003), an intervention designed to address the special treatment needs of youth with emotional and behavioral disturbances and histories of maltreatment or exposure to domestic and community violence.

The Sanctuary Model integrates trauma theories (Bloom, 1997), an enhanced therapeutic community philosophy (Bloom, 1997), and recommended child treatment strategies that address post-traumatic symptoms, developmental disruptions, and unhealthy accommodations to traumatic experiences (Friedrich, 1996).

A fundamental premise of the intervention is that the treatment environment is a core modality for modeling healthy relationships among interdependent community members. This trauma-informed systems approach was described in a previous issue of *Residential Group Care Quarterly* (Bloom, 2003). In the setting of a residential treatment center, the model was operationalized through:

- a series of staff dialogues and self evaluations of residential units' structure and functioning,
- staff training and ongoing technical assistance,
- twice-daily community meetings coled by staff and youth,
- a range of psychoeducation exercises that staff use in their daily interactions with youth, and
- weekly psychoeducation groups

(Duffy, McCorkle, & Ryan, 2002) to teach the knowledge and skills needed to progress through four stages of recovery (i.e., safety, emotions management, loss and grieving, and future orientation; Foderaro & Ryan, 2000).

The evaluation project was conducted as a partnership between researchers of Columbia University School of Social Work, the Center for Trauma Program Innovation of the Jewish Board of Family and Children's Services in New York City, and the model developer, Sandra Bloom.

The project originated from the host agency's desire to enhance its service delivery by incorporating a new approach to meeting the special needs of youth in its residential treatment programs. The research component was funded through an exploratory/developmental research grant by the National Institute of Mental Health as part of an initiative to promote research on interventions for youth violence.

Evaluation Methods

The project took place in a suburban community outside New York City where the Sanctuary Model is being implemented in three residential treatment programs on one large campus. The model was piloted in four residential units that self-selected to participate in the initial phase of the project.

The staff training protocol and manual was developed and piloted between February and August 2001, then four additional residential treatment units

were randomly assigned to implement the Sanctuary Model the following fall. Eight other units that provided the standard residential treatment program served as the control group.

Changes in the therapeutic communities and in youth were assessed every three to six months through April 2003. Results of the Sanctuary Model units were compared to results of units with standard residential services.

Although the Sanctuary Model was in a very early stage of implementation, the evaluation was guided by hypotheses that projected what specific outcomes were expected to occur in the therapeutic communities and in youths. We expected to find greater changes over time in the Sanctuary Model units than in the standard residential treatment units in the following areas:

Therapeutic Communities

- Increase in perceived sense of community/cohesiveness
- Increase in democratic decision-making and shared responsibility in problem-solving
- Reduction in critical incidents and use of physical restraints

Youth

- Reduction in traumatic stress symptoms
- Increase in level of self-esteem
- Greater internal locus of control
- Greater use of social network
- Improvement in decisionmaking and problem-solving skills
- Decrease in aggressive behavior

Youth Demographics and History

Demographic and historical data were obtained from clinical records at baseline. History of abuse and neglect was abstracted from these records using the Maltreatment Classification System developed by Barnett, Manly, and Cicchetti (1993). Exposure to violence in home, community, or neighborhood was assessed through the My Exposure to Violence instrument (Buka, Selner-O'Hagan, Kindlon, & Earls, 1997).

Youth ($N = 165$) ranged in age from 12 to 20 years, with a mean age of 15. Seventy-three percent were male and 27% were female. Fifty-one percent were black, not Hispanic; 34% were Hispanic; 11% were white; and 4% were Asian, Pacific Islander, or biracial.

Youth averaged six prior placements, including an average of three psychiatric hospitalizations. Thirty-four percent had experienced at least one substantiated incident of physical abuse, 12% had at least one substantiated incident of sexual abuse, and 45% had at least one substantiated incident of neglect. Most youth experienced multiple incidents of maltreatment.

A self-report of lifetime exposure to violence showed that 42% of youth had seen someone else attacked with a weapon, and 23% had been attacked with a weapon themselves. Twenty percent reported having seen someone else shot, and 11% reported having been shot at (Rivard et al., 2003).

Implementation of the Sanctuary Model

Our evaluation emphasized an assessment of the processes of model implementation. Could we successfully operationalize and measure incremental changes in the therapeutic communities? Would staff and youth understand the model, accept it, and see its value? Would successful implementation actually lead to change in staff and youth behaviors?

We documented progress in implementing the model using consultants' process notes and periodic reviews of the Sanctuary Project Implementation Milestones checklist, which contained a list of observable criteria. Researchers gathered qualitative data on staff perceptions of the course of implementation, and challenges in implementing the model using focus groups. We also used focus groups to see youths' understanding of the model and their impressions of its effectiveness.

Would staff and youth understand the Sanctuary Model, accept it, and see its value?

Across the eight units that implemented the model, scores on the Sanctuary Project Implementation Milestones criteria ranged from 66% to 92%, with a mean of 78%. The slowest and most difficult component implemented was the weekly psychoeducation group. We saw greater implementation among those units exposed to the model longer, those serving girls, and those with leaders who had greater enthusiasm and commitment to the model.

Through focus groups with staff, we learned one of the most important findings concerned factors that facilitated not only implementation, but also consistency in using the model. These factors included building in structured times for discussing implementation and team-building, proceduralizing use of the psychoeducation tools, general openness of staff and youth to the model, acknowledging small successes to build enthusiasm, helping youth gain a deeper understanding of the trauma recovery framework, group cohesion, providing community-level incentives for positive community behaviors, and program

leadership (Rivard et al., in press).

From youth focus groups, we learned that they both understood and thought they could benefit more from the Sanctuary Model in units where there was stronger implementation.

Therapeutic Community Outcomes

The short form of the Community Oriented Programs Environment Scale (COPEs; Moos, 1996) was used to assess the extent to which units were operating as therapeutic communities along selected dimensions. Trends in the frequency of critical incidents were then measured by analyzing data from the agency's management information system.

We found no significant differences between the Sanctuary Model units and the standard residential treatment units during the first two waves of measurement. By the final wave of measurement, however, we found significant differences between the groups via independent t-tests, with the Sanctuary Model units improving on the following constructs of the COPEs: support ($p < .05$), spontaneity ($p < .01$), autonomy ($p < .05$), personal problem orientation ($p < .05$), safety ($p < .05$), and in the total score ($p = .001$). We are still analyzing data measuring trends over time in the frequency of critical incidents that occurred in the residential treatment units.

Youth Outcomes

The following instruments were used to assess youth outcomes that were hypothesized to be responsive to the Sanctuary Model: Child Behavior Checklist (Achenbach, 1991), the Trauma Symptom Checklist for Children (Briere, 1996), the Rosenberg Self Esteem Scale (Rosenberg, 1979), the Nowicki-Strickland Locus of Control Scale (Nowicki & Strickland, 1973), the peer form of the Inventory of Parent and Peer Attachment

(Armsden & Greenberg, 1987), the Youth Coping Index (McCubbin, Thompson, & McCubbin, 1996) and the Social Problem Solving Questionnaire (Sewell, Paikoff, & McKay, 1996).

Although baseline data were collected for 165 youth, substantial attrition occurred due to youth being discharged through usual program operations. By study end, 87 youth yielded three waves of data (i.e., baseline, three months, and six months). No significant differences were found comparing baseline and three-month measures. On repeated analyses ($N = 87$) comparing baseline and six-month outcomes, however, we found a few differences by time and group, favoring youth in the Sanctuary Model units. These were on the incendiary communication/tension management construct of the Youth Coping Index ($p < .05$), locus of control ($p = .15$), and the verbal aggression construct of the Social Problem Solving Questionnaire ($p = .15$).

Discussion

Results were modest and consistent with a newly implemented intervention, especially considering that rates of implementation varied across units. The few positive youth findings offer promise that full implementation may yield greater youth benefits.

The finding that the treatment environments of the Sanctuary units were functioning at significantly higher levels than the standard residential units by the final wave of data collection suggests that implementation was becoming stronger with time.

In studying children's service systems, Glisson & Hemmelgarn (1998) found that organizational climates with greater job satisfaction, fairness, cooperation, personalization, and lower levels of conflict were associated with both service quality and positive outcomes in children's psychosocial functioning. These findings validate the current project's intensive program

development efforts aimed at strengthening the treatment environment for the benefit of staff and youths. More analyses of the data will follow.

Some of the most important lessons learned from this project focus on the need to support implementation efforts with more intensive onsite technical assistance, promote ongoing evaluation to assess change in the treatment environments and youth over time, and incorporate the use of brief behavior checklists that can be used as part of the regular program operations, and that may be more sensitive to change than measures of three-month self-reports of youth.

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Are Point and Level Systems the Answer?

By Lloyd B. Bullard

Behavior modification techniques, such as point and level systems, are a fundamental therapeutic approach that managers, therapists, and child care workers use in treatment and care programs for children in residential facilities.

Behavior modification is thought to offer proven guidelines and procedures for diagnosing, treating, and managing children in residential care (Buckholdt & Gubrium, 1980). Unfortunately, residential treatment programs in the United States rely too much on point and level systems to bring about behavioral change, often sacrificing opportunities to build relationships between youth and staff members.

Point and level systems are one of the most common behavior modification programs used in residential care facilities (VanderVen, 1999). Point and level systems are used to manage behavior that is both observable and accessible to staff intervention by concentrating on overt behavior as opposed to internal dynamics (Cohen, 1986). The main focus of a point and level system is to control every aspect of a child's actions in the milieu, rather than fostering development of internal control through interpersonal interactions with staff (VanderVen, 1999).

Point and level systems essentially award points to children for positive behavior and deduct points for negative behavior (VanderVen, 1999). Staff constantly monitor the behavior of residents (Buckholdt & Gubrium, 1980) and points are tallied periodically to ascertain children's compliance with the current system and determine their status level (VanderVen, 1995).

Based on points earned, a child may be promoted to a higher level; points subtracted due to rules infractions may cause a child to be demoted to a lower level. With each level increase a child receives additional privileges, and with every demotion the child loses privileges. Earning and totaling points may appear to be an objective method for determining a child's level. But by including such things as the child's ability to follow rules and a willingness to address individual behavior goals, the process becomes increasingly subjective.

Failures are a part of every child's normal development, but point and level systems may encourage children to view failure in a negative light.

Durrant (1993) points out that level systems may appear to be firmly established on the notion of rewarding success and positive behavior, but may, in fact, contribute to failure. Failures are a part of every child's normal development, but point and level systems may encourage children to view failure in a negative light.

Many children present problem behaviors, and child care workers are left with the difficult task of managing and helping the child to manage his or her own behavior. This usually results in the child not earning points nor achieving a higher level with greater privileges. Many children, therefore, experience an even greater sense of failure within point and level systems (Durrant, 1993).

One of the most significant factors that should be integrated in the delivery of residential services is favorable interpersonal interactions between staff and residents (Garfat, 1994; Krueger, 1991). Interpersonal interactions help establish and build relationships between staff and residents. Such interactions are essential in fostering trust and building self-esteem among youth. Once a bond of trust is established, self-esteem increases and openness to positive development persists. Conversely, the absence of interpersonal relationships may have an adverse effect.

Since the 1960s, this country has experienced a significant increase in new approaches and models for managing and treating emotionally disturbed children. In spite of this, no consensus points to the best approach or model (Bertolino & Thompson, 1999). Nonetheless, many of these models use behavior modification techniques to induce the desired behavior.

Although research examining the effectiveness of point and level systems is scant, several well-known leaders in the field have touched on the subject. Some researchers believe point and level systems have many limitations and are not adequate tools for supplying residents with personal interactions (Armstrong, 1993; Buckholdt & Gubrium, 1980; Durrant, 1993; Fox, 1994; Goldfried & Castonguay, 1993; VanderVen, 1993, 1995, 1999).

Considering the main objective of a point and level system is to control a child's behavior, the presence of substantial interpersonal interactions is unlikely. Yet interpersonal interactions are clearly necessary for forming

relationships, a fundamental component of child and youth work (Abel & Nelson, 1990; Fewster, 1990; Krueger, 1991; Rose, 1991; VanderVen, 1999).

Although McInnis & Marholin (1977) do not specifically mention point and level systems, their research indicates that this kind of individualized program is difficult to implement successfully within residential facilities. One must ask whether point and level systems provide sufficient interpersonal interactions for residents in these settings.

In fact, point and level systems can provide sufficient interpersonal interactions for the normal development of adult-child relationships. But this would require workers to consistently communicate with the child and provide guidance and reinforcement.

This does not suggest that point and level systems are the best approach for producing positive outcomes. Agencies using various point and level systems may have very different results. The agency's leadership, organizational culture, staff investment, population served, and the methodology used to implement the system affect how these systems or any others might function within an agency.

Interpersonal interactions are clearly a necessary condition for forming relationships, a fundamental component of child and youth work.

Behavior models must be individualized and must take into account the developmental stage of each child (VanderVen, 1995). Rather than require children to conform to the model, the model must adapt to the unique needs of every child. In addition, the behavior model must be as simple as possible; any child or youth in the program should be

able to understand the model and explain it. Many point and level systems are accompanied by a large handbook explaining systems that may be difficult to read and hard to understand; this practice must be revised (Gutkind, 1993).

It's particularly crucial that point and level systems do not give consequences to children for every rule infraction (VanderVen, 1995, 1999). Rather, they should rely more on natural consequences, discussions with the children about the reason for their behavior, and analysis of the need the child was attempting to fulfill.

To create and develop an appropriate behavior model for children, agencies must provide residents with programming that offers training in everyday skills and social skills, challenging and meaningful activities that increase coping skills and team cohesiveness, and some socially redeeming qualities. In addition, staff must be invested in providing these children and youth with quality care.

And that's not enough. The agency must also invest in its employees, providing them with appropriate high-quality training in communication, relationship building, behavior support, active listening, team building, and cultural diversity.

Many agencies aren't interested in using point and level systems for a number of reasons, but they're still faced with the challenge of selecting or developing a behavior model. A plethora of other alternatives are available to those agencies not interested in using point and level systems.

Whether an agency is selecting or developing a behavior model, the first step should include a review of the agency's mission and philosophy, which should embrace an overall goal for clients served. This process should not be limited to administrative staff, but should include all disciplines and staffing levels.

Many agencies make the mistake of starting their selection process for a

behavior model by reviewing the numerous models currently available. By clearly understanding its mission and philosophy, as well as the agency's desired outcomes for children and youth, an agency can develop a framework to achieve those outcomes.

Is the model transferable to the child's next placement or home? Does the model create a realistic approach for addressing the child's behavior? Can all staff implement the model consistently?

The next step requires the agency to decide whether to opt for one of the available models, such as the teaching-family model, guided group interaction, positive peer culture, positive youth development, risk and resilience, caring profile, or numerous others, including a design of their own. If the agency chooses one of the available models, it may need to alter the model to meet clients' needs. The agency must ensure that the model does not require residents to fit into it, but rather that the model can be adapted to the client's individual needs (CWLA, 2002). The agency should also answer the following questions: Is the model transferable to the child's next placement or home? Does the model create a realistic approach for addressing the child's behavior? Can all staff implement the model consistently?

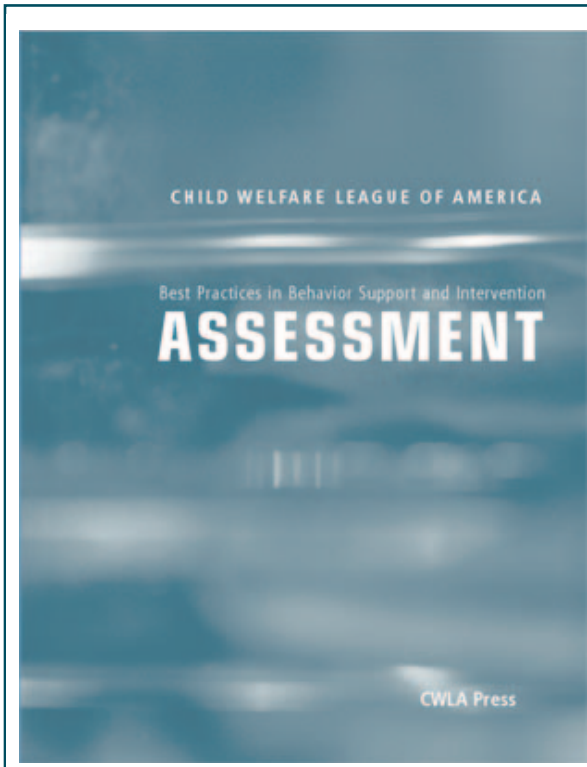
Regardless of the abundance of available models, an agency may decide to develop and implement its own model. No matter which track the agency chooses, direct care workers, clinical staff, administrative staff, and any other staff responsible for the supervision and care of the clients should actively participate in the process.

To achieve staff buy-in, an agency must get equal participation from all staff members. The success of any behavior model depends largely on the staff's investment. Involving the direct care workers at the onset is extremely important, as they are the ones who spend the most time with residents and will be primarily responsible for implementing the model. Lastly, for any behavior model to be successful, an agency must to incorporate the genuine involvement of children.

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Best Practices in Behavior Support and Intervention Assessment

This assessment instrument will help agencies improve their behavior support and intervention policies, practices, and procedures. Agencies that perform the self-assessment will be able to pinpoint how they can ensure the safety of their clients and workers without causing children more harm than they have already experienced. See page 2 of this issue for more information. To purchase the Child Welfare League of America's *Best Practices in Behavior Support and Intervention Assessment*, for \$8.95 plus shipping/handling and applicable sales tax, there are five easy ways to order: CWLA, P.O. Box 932831, Atlanta, GA 31193-2831; Phone: 800/407-6273; Fax: 770/280-4160; or Online: www.cwla.org/pubs

Q: *Is Residential Care a Cost-Effective Service?*

POINT: Most residential care providers are badly underfunded—it’s almost impossible to find a residential provider that’s reimbursed at its level of cost. In spite of the fact that it’s undervalued and underfunded, however, residential care is a cost-effective service that is necessary and effective.

By Bill Powers

Mrs. R. told all of us earlier in the day she was most definitely not going to cry. Now it’s time for the final goodbye, the last in a series of final goodbyes, and we’re all standing in the lobby of our residential treatment center, crying. Mrs. R. tells us we are miracle workers, that she had given up on seeing her son reach his 18th birthday, and that we have restored him to life. She repeats that we just don’t seem to appreciate what we have done for her family.

Similar, if less dramatic, scenes play out every day across the country. And this scene is at the very heart of this discussion: Why do we consistently undervalue a treatment service that restores life to “lost” children and their families? How does a service that provides hope to often voiceless children and their families justify its expense?

To draw comparisons between physical and behavioral health care, years of successful cardiac, neurological, and organ transplant surgeries are no longer questioned in spite of their relatively high cost. Yet in behavioral health care for children, particularly for those in residential treatment centers, we find ourselves constantly defending the cost of equally important life-saving services. Why? Is it the lack of publicity regarding the positive outcomes of residential treatment? Is it the voiceless nature of the population served?

Critics of residential treatment often cite its high cost and lack of hard outcome data. Yet given its high cost, entry into residential treatment is almost always preceded by a long list of failures in less restrictive, less

see POINT, page 10

COUNTERPOINT:

Residential care is a costly, overused service that does not generally produce positive outcomes. Although residential care is useful under limited circumstances, the funds spent on it would, in general, be better used supporting birth and foster families.

By Richard P. Barth

Efforts to contrast the strengths and weaknesses of residential and foster care are long and storied (Wolins & Piliavin, 1964). These deliberations have been largely conceptual rather than evidentiary—highlighting the potential risks and benefits of each approach. Until recently, there wasn’t enough scientific evidence to fully inform this debate.

Even now, large unanswered questions remain about the effectiveness of residential care in contrast to alternatives. Cost-effectiveness comparisons are the most limited, because they require estimates of the size of the improvement in outcomes for residential care and its alternatives, as well as short- and long-term benefits.

A careful treatment of this question requires bundling some rough estimates and overgeneralizations into an argument. Still, the resulting conclusion is reasonably robust: Residential care consumes a substantial portion of the nation’s children’s services budget yet does not offer commensurate benefit to youth, their families, or society.

Research comparing the outcomes of residential care with other community-based services is beginning to support a strong case that residential care is not a comparably effective approach to serving youth. Direct experimental comparisons between hospitalization and multisystemic family therapy (MST) and between MST and incarceration (Henggeler, et al., 2003, Borduin, et al., 1995) show that MST works as well or better.

The same is even more clearly true in the randomized control trials comparing multidimensional treatment foster care (MTFC) against group care for juvenile offenders. At

see COUNTERPOINT, page 11

expensive treatment settings. Unfortunately, this failure path not only rules out less expensive treatment options, but also directly contributes to the high cost of residential treatment. Each successive failure—sometimes as many as 7 to 10—reinforces the child's lack of faith and trust in the system.

Restoring a lost childhood to these youth who have bounced through the system requires a large cadre of caring, trained professional staff. Reaching families, a critical component of successful residential treatment, requires good detective work and enormous patience and persistence.

Furthermore, damage caused by years of abuse and neglect, compounded by repeated failures in less restrictive settings, is not easily or quickly undone. Each child and his or her family must be met on their own terms to engage in a therapeutic relationship. Gains achieved through hard work in the residential setting must be replicated and transferred to the home. Once again, this transfer of knowledge and skills requires truly caring and experienced staff working directly with families.

To accomplish this complex and difficult work, residential treatment centers usually receive less than 90% of their true costs from public funding sources. Fundraising and endowment draws, if there is an endowment, must make up the difference. Faced with the constant threat of economic extinction, residential treatment providers prioritize direct services to children and their families. As a direct result, research that would produce meaningful outcome data is rarely funded or is severely underfunded.

In spite of these funding limitations, residential treatment providers are increasingly conducting their own outcome studies and collaborating with peer agencies to produce more statistically significant comparison studies. And they're paying attention to carefully matching demographics to avoid drawing conclusions on noncomparable populations, a failure of many earlier studies. Outcome data across life domains are commonly collected at 6, 12, and 18 months post-discharge.

A recent CWLA study of the research literature reveals that characteristics of residential treatment centers that have been correlated with long-term positive outcomes include high levels of family involvement, supervision and support from caring adults, a skill-focused curriculum, service coordination, development of individualized treatment plans, positive peer influences, enforcement of a strict code of discipline, a focus on building self-esteem, a family-like atmosphere, academic support, presence of community networks, a minimally stressful environment, and comprehensive discharge planning. (Bullard & Johnson, in press).

In spite of the increasing emphasis nationally on collecting meaningful outcome data, residential treatment continues to be a seriously undervalued treatment service. Could the disparity in public recognition and subsequent adequate funding also be related to the tar-

get population? Although the high cost of open heart surgery is borne by all socioeconomic classes, including corporate executives, residential treatment's target population comprises voiceless, disenfranchised children and their desperate families.

Our mission is clearly defined. We must continue to gather and publicize meaningful outcome studies on the benefits of residential treatment. We must continue to search for common best practices that produce these beneficial results. We must not allow critics and cynics to deter us from providing care for Mrs. R. and other parents desperately seeking help for their children. We must continue to support these children, our families, and each other.

Bill Powers is Executive Director, Bonnie Brae, Liberty Corner, NJ.

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FEEDBACK

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two years' follow-up, the MTFC group was in the normative range, whereas rates for group care youth were at least four times higher (Eddy, Whaley, & Chamberlain, 2004). Many youth who were thought to be best served in group care did as well or better in alternative forms of care. These findings make dubious the idea that a child needs residential care. A child may need specialized or intensive services, but these services may not be best provided in a group care setting.

Although group care is often envisioned as a place with consistent structure, youth in group care report they are far less likely to receive consequences for problem behavior than youth in high-quality treatment foster care.

Chamberlain and her colleagues (1996) have shown that youth who are randomly assigned to MTFC and remain there for at least six months have better behavioral outcomes than youth placed in group care. Youth in group care often have deteriorating performance because of consistent exposure to deviant peers (Eddy & Chamberlain, 2000). This is consistent with basic research showing the acceleration of negative behavior that follows the convening of adolescent groups (Dishion, McCord & Poulin, 1999).

Further, although group care is often envisioned as a place with consistent structure, youth in group care report they are far less likely to receive consequences for problem behavior than youth in high-quality treatment

foster care (Chamberlain, Ray, & Moore, 1996).

Such a brief review cannot do justice to the many types of residential care or to the range of comparisons of residential care to other services. Family-focused approaches to residential care are emerging as clearly superior to others (Whittaker, 2000). Residential care that involves families appears to achieve better outcomes and, possibly, higher levels of cost-effectiveness (Hooper, Murphy, Devaney, & Hultman, 2000; Landsman, Groza, Tyler, & Malone, 2001; Romankys, Lyons, Lehner, & West, 2003). These findings are consistent with social science research: "The cost-effectiveness of group interventions is retained if focus is on the parents and aggregating young adolescents is avoided" (Dishion, McCord, & Poulin, 1999; p. 762).

The high level of staff turnover and requisite retraining also raises concerns about the cost-effectiveness of group care. Combined with higher costs for insurance and 24-hour care, as well as higher salaries for greater levels of professional staff in many facilities, the overall cost of residential care is two to five times higher than typical treatment foster care (Barth, 2002; MOLA, 1999). If these resources were devoted to specialized treatment of children's needs, and used to address family problems that detract from providing successful parenting, they might be more cost-effective.

Out-of-home care resources are not well matched to children's needs. Although there may be a difference between the level of problems facing children in group care and those in treatment foster care, among children in group care, there appears to be very little correspondence between the level of behavior problems of youth and the level of placement setting (Berrick, Courtney, & Barth, 1993).

Nor does there appear to be much difference in programming or services between high-cost and lower-cost facilities (Coen, Libby, Price, & Silverman, 2003). Indeed, many group care placements are made without assessing the placement's ability to meet the needs of children (MOLA, 1999).

Purchasing good care for children can be costly—strategies that adequately address a range of child and family concerns of children in foster care and community settings are not readily available nor inexpensive. But simply because group care is more available than most emerging evidence-based alternatives is no justification for its use. Evidence in favor of group care's effectiveness is quite weak, and it must be balanced against the real possibility that conventional group care contributes to a worsening of children's conditions.

Simply because group care is more available than most emerging evidence-based alternatives is no justification for its use.

This conclusion must be understood with the knowledge that few cost-effective interventions are available for troubled children, and the evidence is inadequate to precisely order cost-effective interventions. Even the most promising interventions have not been widely tested by independent assessors in a range of settings. And not all studies adequately account for children or families who leave the research before completion.

Some children cannot or will not be served in treatment foster care or in family-based care because it's not their

parent's preference or there are no locally available providers. In that case, group care may be the safest available alternative.

Group care, with a family-focus, has the potential to be a valuable component of the children's services armament (Gibson & Noble, 1991). As currently delivered, though, group care's value for children and families is not justified by the cost to governmental agencies. But if group care were redesigned to build on the strengths of families, there's a good chance that might change.

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In the next Residential Group Care Quarterly Point/Counterpoint...

Question: Should all organizations that provide training for behavior support and crisis management be required to certify their training model?

Point:

Certification is necessary and long overdue. Numerous training organizations provide national and international behavior support and crisis management training, yet their individual training models are not accredited or certified. States have approached this dilemma in several different ways, from limiting the approved training models for use in their state to requiring all training models to be approved in advance. We're left with a very disjointed system, and in some cases no system at all, to ensure these models are safe and effective.

Counterpoint:

Certification may not be the answer to ensure behavior support and crisis management training models are effective. More and more agencies are learning that behavior support and crisis management training in itself is not the answer to reducing the use of restraint and seclusion. Agencies have become much more creative in their approaches to reducing restrictive procedures. But by certifying these training models, we may create an atmosphere that views training as an end all. Certification may place more attention on the certification process and trainings, and less on what agencies are doing internally to reduce their use of restraint and seclusion.

Shame and Anger: Recognizing the Link Between Maltreatment and Malcontent

By Marge Sullivan

For some years now, the Institute for the Study of Child Development/Pediatrics has concentrated its research on the ways in which shame explains the diverse behavioral problems seen in children who have histories of maltreatment.

Everyone agrees physical abuse and neglect are bad for children. But the sheer variety of problems reported for these children pose a significant challenge to those who serve them, plan the treatment programs, and direct social policy. Studies suggest that maltreated children can be aggressive, depressed, antisocial, or clingy. They may be withdrawn or sullen and bullying.

It is critical to understand how such diversity arises in maltreated children, because if we understand the processes by which maltreatment leads to particular outcomes, we will do a better job of managing and treating behavioral problems. We will also be better able to identify those children at greatest risk and those who are more resilient.

Models of Maltreatment

Until recently, most research on the aftermath of maltreatment tacitly endorsed a trauma model of maltreatment. Typically, physical abuse or neglect were viewed as traumatic events and, therefore, the direct cause of subsequent behavioral difficulties. The form, amount, and severity of maltreatment—or some combination—is still thought to explain the diverse problems seen in children. The trauma model is simple to understand, but it

explains little and offers few practical strategies for treatment apart from prevention of the trauma in the first place.

We believe a psychological model of maltreatment provides a more comprehensive, process-oriented account of how maltreatment leads to poor behavior and suggests a number of treatment approaches. In the model we have articulated and are now evaluating, the self-evaluative emotions by which children respond to their experiences of maltreatment and other personal frustrations are the most important.

These emotions, especially shame, may serve as the critical psychological process linking maltreatment to poor behavioral outcomes. Theory and our research suggest that shame and the self-blaming beliefs that accompany this emotion are critical mediators between a history of abuse and neglect and behavioral difficulties.

Shame and Coping

Shame is an emotion that emerges as soon as children begin to understand who they are. In their second year of life, most children develop an important mental capacity that allows them to recognize themselves in mirrors and other representations, to refer to themselves, and to be self-aware. Lewis (1992) calls this capacity the “idea of me” or explicit self-consciousness. Its emergence makes possible a set of emotions important to human social life, such as embarrassment, jealousy, and empathy. By the time they are 3 years old, children have begun to master an initial set of standards,

rules, and goals as part of their early socialization. Additional mental abilities acquired during this period allow children to begin to compare their behaviors to these standards, rules, and goals, which may lead to shame. This emotion can be seen in a child’s body, face, and verbal behavior from the age of 3, and perhaps earlier.

By age 4, children already exhibit individual differences in the amount of negative emotions shown in response to failure. Thus, even young children experience shame, and some develop a bias toward it, which undermines their adjustment.

Shame is an intense, painfully negative emotion. When children experience shame, the most common response is to hide, disappear, or run away. All people try to cope with shame to avoid its pain, and many do so in maladaptive ways. When shame is not coped with adaptively, sadness and depression may result. Some individuals try to rid themselves of shame through hostility and anger. They may become enraged and literally attack those whom they believe have shamed them.

Shame’s Role in Sexual Abuse

Shame plays an important role in adjustment following sexual abuse. When children are abused, their experience of shame following discovery is what primarily determines the behavioral symptoms that follow, both immediately after the event and in the longer term. Children who showed more shame at the time of abuse discovery showed more depression,

eroticism, and effects of post-traumatic stress disorder one year later (Feiring, Taska & Lewis, 1999).

Moreover, changes in shame and self-blame over time predict recovery following the abuse. Children whose shame decreased were doing better a year after discovery, as measured by fewer behavior problems, less depression, and better self-esteem. Children's adjustment one year after the abuse was not predicted by the severity of the initial abuse, but was a factor in their shame. (Feiring, Taska & Lewis, 2002).

Shame in Physical Abuse and Neglect

Shame may also explain some of the similarities in behavioral difficulties that commonly arise from physical abuse and neglect. The literature suggests that although depression may occur in the aftermath of both physical abuse and neglect, aggression and hostility appear to be more prevalent in abused children, especially boys, presumably because of their greater exposure to harsh punishment. Shame, however, may underlie both these difficulties. Children's shame may interact with the form of maltreatment and produce either greater depression or greater anger.

Our work shows that maltreated children differ in their self-evaluative emotions because of the harsh treatment they receive. Preschoolers with histories of physical, sexual, and emotional abuse or neglect showed different emotional responses to success and failure relative to a matched control group (Alessandri & Lewis, 1996). The occurrence of physical and excessively harsh, critical verbal punishment may cause children to feel shamed, unloved, and worthless. High demands and frequent, severe punishment are thought to be characteristic of physically abusive parents but may also occur among neglectful parents as well.

To test whether shame influences the effect of maltreatment on children's expressions of anger, we studied 86 children with substantiated case records of abuse, neglect, or both, as well as a

matched community sample of 89 children without such histories. We counted all recorded allegations of physical abuse and neglect meeting standard definitions of maltreatment, whether they were substantiated or not. Record abstractors were able to achieve 85% agreement. Disagreements were resolved by majority opinion following team review and query with child protective services.

To quantify the amount of physical abuse, children were assigned a physical abuse rank as follows: controls were assigned 0, representing no known physical abuse. Children with abuse records were scored as 1 plus the number of physical abuse allegations to arrive at their final score. Neglected children were assigned numbers using a similar system. Children's shame, anger, and sadness in response to a mild failure experience (not completing several tasks by the time a bell sounded) were scored from videotape.

Regression analyses examined the associations between level of physical abuse, shame, and anger. We also tested the shame–anger model for neglect and found that level of physical abuse was related to children's shame, and the amount of shame was related to their anger. Interestingly, maltreatment itself did not lead directly to anger. It led to shame, and shame lead to anger. Physically abused children, therefore, may be prone to anger because they feel shamed.

When we examined the relation between levels of neglect, shame, and anger, only shame was related to children's anger. Neglect was unrelated to shame. Shame thus appears to be a risk factor for increased anger in all maltreated children. Physical abuse promotes shame, whereas neglect does not seem to do so, at least not directly. Shame in neglected children may be related to either aspects of child temperament, particular features of their parenting experience that are not a general feature of neglect, or some combination of these.

High rates of harsh physical and verbal punishment seem to give children

the message that they are very bad and unable to change. This punishment need not reach a criminal level of abuse to have such an impact on the child's developing self-system. Because *badness* is a core judgment, harsh punishment may signal profound failure of the self to the young child, thereby leading to shame. Our findings suggest that feelings of shame promote tendencies toward anger in maltreated children's responses to even mild failures. These negative emotions are likely to underlie the hostility and aggression often described in maltreated children.

Our findings suggest that neglect and physical abuse show somewhat different patterns. Although shame seems to lead to greater feelings of anger in both forms of maltreatment, the physically abused child is at especially high risk, since abuse leads directly to shame, leading in turn to greater anger.

In neglected children, anger may occur only in those who are shamed either because of their temperaments or particular life experiences that foster this emotion. This differential pattern by maltreatment suggests different intervention approaches may be needed to help children manage their emotions in the aftermath of physical abuse.

Margaret W. Sullivan, PhD, is a professor at the Institute for the Study of Child Development, University of Medicine and Dentistry of New Jersey, Robert Wood Johnson Medical School, New Brunswick, NJ.

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Legal Proceedings:

NACC's Children's Law Conference in Vegas September '04

The National Association of Counsel for Children (NACC) will hold its 27th National Children's Law Conference, "Representing Children, Families, and Agencies in Child Welfare, Juvenile Justice, Custody, and Adoption Proceedings" in Las Vegas, Nevada, September 7-10, 2004. Tailored to those working in the fields of law, medicine, social work, and education, the conference generally draws more than 500 professionals working in child welfare, juvenile justice, and family law.

Shay Bilchik, President & CEO of the Child Welfare League of America, will deliver the keynote presentation. Edward Lazarus, former editor of the Yale Law Journal and former clerk to Supreme Court Associate Justice Harry Blackman, will discuss the history and current status of the juvenile death penalty. John E.B. Meyers will address *Crawford v. Washington* and other developments in the law of evidence affecting children. Four different tracks offer sessions addressing Abuse & Neglect; Juvenile Justice; Custody, Visitation & Adoption; and Policy


Advocacy. A pre-conference session on developing children's law office practices and procedures will be held on September 7th.

The conference is supported by the American Bar Association, the National Council of Juvenile and Family Court Judges National CASA, CWLA, and many others. Continuing education credits are available. For more information including a full schedule of conference events, contact NACC at 888/828-NACC or visit www.NACCchildlaw.org.

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