RESIDENTIAL GROUP CARE QUARTERLY

VOLUME 6, NUMBER 1 CHILD WELFARE LEAGUE OF AMERICA SUMMER 2005

Residential Treatment: Finding the Appropriate Level of Care

by Shay Bilchik

The following is adapted from a speech by Shay Bilchik, President and CEO of the Child Welfare League of America, at Temple University, March 23, 2005.

I'd like to share with you a kind of fable. The story goes that the devil once held a yard sale and offered all the tools of his trade to anyone who would pay his price.

There they were, spread out on the table, each with its own label—hatred, envy, despair, greed, child abuse, addiction—all the weapons of destruction.

But off to one side lay a harmless looking wedge-shaped instrument marked "discouragement." Old and worn, it was priced far above the rest.

When asked why, the devil explained, "Because I can use this one so much more easily than all the others. No one knows that it belongs to me, so I can use it to open doors that are bolted shut. Once I get inside, I can use any tool that suits me best."

I use this story to introduce the topic of residential care for two reasons. First, residential care is a somewhat discouraged system in today's social services environment. Right now, the whole of that system needs encouragement. Secondly, it deserves to be restored to its rightful place in the array of services, or tools, we use to redirect precious lives and to heal and make whole.

I have two goals: to tell you what I think is militating against the optimal use of residential care today, and to suggest what is working and can work. I will not spend too much time on the negative, because I am hopeful. In spite of the challenges, I see a growing honesty about the shortcomings of all our systems and a growing openness to collaborative, creative solutions.

Systems are resilient, just as children are resilient. As I talk about what we do, about agency programs and interventions, I will connect those to real children and families. They are the reason for the work we do. What we want for them, after all, is not complicated:

- We want all of our children to have someone in their lives who loves them and who they love.
- We want all children to have the opportunity to develop skills that will allow them to find truly meaningful work in their life.
- We want all children to have hope—to wake up every morning knowing there is something to look forward to that today, or the next day, or the day after that.

These are the things we want for ourselves, for our own children, and for the children in the child welfare system. So what do we have in our toolbox to counter the evils of child maltreatment and family dysfunction standing in children's way? Every community needs an array of top-flight child welfare options that includes:

- family support, to strengthen families and prevent maltreatment,
- early intervention and family preservation;
- shelter care;
- receiving homes and assessment centers;
- kinship care;
- residential care, including group homes;
- day treatment;
- foster care;
- therapeutic foster care, such as specialized foster care or treatment foster care; and
- aftercare, linked with an

INSIDE

Family-Centered Practices
The Wyoming Department of Family Services began implementing family-centered practices two years ago in response to the Child and Family Services Review.
—Page 7

Point/Counterpoint
Can the community serve sex offenders?
—Page 9

Residential Group Care Quarterly

Volume 6, Number 1

Residential Group Care Quarterly (ISSN 1529-6954) is published four times a year by the Child Welfare League of America (CWLA). Printed in the USA.

The Child Welfare League of America is the nation's oldest and largest membership-based child welfare organization. We are committed to engaging people everywhere in promoting the well-being of children, youth, and their families, and protecting every child from harm.

A list of staff in CWLA service areas is available on the Internet at www.cwla.org/whowhat/serviceareas.asp.

CHILD WELFARE LEAGUE OF AMERICA HEADQUARTERS
440 FIRST STREET, THIRD FLOOR
WASHINGTON DC 20001-2085
WWW.CWLA.ORG

integrated network of community-based supports for referral and follow-up.

Though residential care is just one piece of this array, it's a significant piece used in child welfare, education, juvenile justice, mental health, and support for the disabled. We estimate about 50% of CWLA's 900-plus member agencies are residential care providers, though for many that function is part of a wider service array. Residential care accounts for 25% of the children's mental health budget nationwide (Marsenich & Meezan 2004). CWLA staff calculated in the mid-1990s that 10,000 agencies nationwide served 225,000 young people in residential settings.

We think these are still reliable numbers, though in this, as in other residential care matters, we don't have a lot of statistics to hang our hats on. Many studies have involved inadequate samples and insufficient rigor. Some have lacked control groups or properly matched controls. Some show positive outcomes for children, and others show little change, or even negative results.

What research clearly shows is we need more rigorous research. We have learned a great deal, however, from research completed to date.

If we don't have a lot of answers in this area, it's partly because we have sometimes asked the wrong questions. I often hear, "Is residential care and treatment good for children?" This is not a fair or complete question because it raises other questions:

- Which children?
- What kind of care and treatment?
- At what point or points on the continuum of services?
- And perhaps, above all, what's best for families—natural or created—enabling them to provide safety and nurturance?

Now we're beginning to get somewhere. The answer, in every case, is that it depends.

A remarkable amount of policy has been created on the untested assumption that residential treatment should always be the last resort, or that alternatives are always preferable. In fact, alternatives aren't always even less expensive, a point worth making because the attractiveness of the previous assumptions derives largely from the untested assumption that home-based services always cost less.

If we test our assumptions, we know we have to start with the individual young person in the context of that young person's family and extended family. To know anything about what is right for that child and other family members, we need to start with intelligent, sensitive assessment. And because we know every child is unique, we have

FEEDBACK

Would you like to sound off on an emerging issue in residential care?

Residential Group Care Quarterly

is the perfect forum for your ideas. Share your knowledge and thoughts with your peers today!

Submissions of all kinds are welcome:

LETTERS TO THE EDITOR NEW TOOLS
COMMENTARIES TREND ANALYSIS
CASE STUDIES REVIEWS

Send submissions to
Residential Group Care Quarterly
Child Welfare League of America
440 First Street NW, Third Floor
Washington DC 20001-2085
202/942-0280, Fax 202/737-3687

to be sure every community has the complete array of options listed above. This way, once we know what an individual child needs at a specific point in time, we will have that service in our toolbox.

Abraham Maslow said, "If the only tool you have is a hammer, all of your problems are going to look like nails."

Research suggests we find it hard to demonstrate success for residential placements because we usually wait too long to pull this particular tool out of the toolbox.

Conversely, if you have an exquisite array of precise tools fitted for every task, and in the hands of sensitive, well-trained professionals, you are equipped to meet the individual needs of each unique child and family. Our profession is both an art and a craft and these are precious human lives, so we need the equipment appropriate for both artists and carpenters. In the long term, combining these tools may cost us less and allow us to be more effective.

I believe we have been asking the wrong questions, to a large extent, because we have had the wrong mental model, or, perhaps more accurately, because an old model has persisted in spite of our professional efforts. The paradigm causing the trouble is the one that organizes interventions on a vertical axis, with family support and prevention at the top and residential care at the bottom. And because language is the primary tool shaping our thinking, we unconsciously perpetuate that thinking whenever we use expressions like "penetrating deeper into the system."

Research suggests we find it hard to demonstrate success for residential placements because we usually wait too long to pull this particular tool out of the toolbox. We assume children have to fail in several other placements before we employ it. A new CWLA position statement being drafted calls this "progress by failure." The result is that by making sure more intensive options are not used too soon, we are almost guaranteeing they will be used too late.

I use the language "children fail in placements" because that is how we talk. In fact, very often it is adults who fail children by not matching the environment to their needs. As a system, we sometimes hew rigidly to the "progress by failure" method, despite clear-cut research that good outcomes usually occur in inverse proportion to the number of placements.

We stick with a low-level intervention not only until it fails, but also until we can prove it has failed. This creates a system far more adept at recognizing risk, weakness, and pathology than recognizing and building on individual's and families' strengths. The federal emphasis on least restrictive placements, dating from the Adoption Assistance and Child Welfare Act of 1980, reinforces this vertical model. At the time, this meant the least restrictive, appropriate placement, but somehow that nuance got lost over time.

We need to get a different model in our heads and the heads of policymakers—one that arrays all possible interventions on a dynamic horizontal axis, where residential treatment can be the proper choice at any point. Residential treatment might be the first stop for a particular child. It might be used to prepare the child and the family for adoption, as some programs have successfully done. For some children, it might be needed at more than one point along the continuum. For many, it may not be appropriate at any point.

One reason we don't have much good research on the efficacy of residential care is that foundations and the federal government are less interested in funding research on residential care than on other interventions. I'm sure this is a response to the unconscious image of residential care as a kind of cul-de-sac in the system. Then, of course, less evidence leads to still less funding, so the circle gets vicious. This isn't a nice way to treat a good treatment modality.

Because children funnel down into residential treatment, they arrive with increasingly complex and recalcitrant problems. And because state budgets are squeezed, and this kind of care is not usually a high priority, providers are asked to treat more children and more challenging children—who have had more previous placements—in less time, with less staffing, less training, and fewer resources of every kind.

Suffolk University and the Children's League of Massachusetts documented this dilemma for 45 agencies in 1999. As a few examples, the number of children these agencies saw from 1996 to 1999 increased 115%, and the number diagnosed with bipolar disorders increased 152% (Beinecke 1999). We have reason to believe the situation is bleaker today. It is not hard to become discouraged in such a landscape.

On the bright side, more programs are reporting positive results from rigorous research, including Girls and Boys Town (formerly Boys Town). The WAY Program at Children's Village in Dobbs Ferry, New York, and the statewide Indiana Association of Research Child Care Agencies Outcome Project are two others. Canadian and Israeli studies have also shown positive outcomes (Blackman, Eustace, & Chowdhury 1991; Weiner & Kupermintz 2001). Pennsylvania has a number of good programs, including the Children's Aid Society, Choice Services, Devereux, KidsPeace, Lutheran Children and Family Service, Pathways, and Youth Service. Evidence of our ability to be effective is mounting.

We need to get a different model in our heads...one that arrays all possible interventions on a dynamic horizontal axis, where residential treatment can be the proper choice at any point.

Research has identified several characteristics of effective residential care programs. Since the need for residential care is not going away, no matter how unpopular it becomes, our best hope is to build on these characteristics. I will focus on four.Research tells us effective programs

- value and engage families and are committed to finding permanent connections for every child, even when parents cannot be those connections;
- use competent, individualized assessment of strengths and needs, and ongoing measurement of progress;
- offer an array of positive, competency-centered therapies; and
- plan for aftercare from the day of admission, interfacing with the community-wide network of services in other relevant areas, including the schools.

Value Families

Research shows the gains children make in residential care are lost when they return to their communities unless we engage parents from the beginning. Families and extended families need to be involved respectfully and creatively as the leading authorities on their children.

The Children's Bureau's analysis of the Child and Family Services Review (CFSR) of all 50 states showed a pattern of failing to adequately involve families in the child welfare system as a whole (Children's Bureau 2005). This is one area in which every state had less than satisfactory outcomes. In particular, the CFSRs noted a failure to engage fathers.

On the plus side, the reviews showed better outcomes for states where families were engaged; where, for example, workers valued family visits and spent reasonable amounts of time with parents; where they worked to keep siblings together, and where they used family group conferences effectively.

When helpers and family members respect each other, both are likely to stick around and be there for the child. That's important, because evidence shows that stable relationships with dependable, caring adults are important factors for any successful program.

Successful programs break down mental and physical barriers between in-home and out-of-home services by bringing the family into the agency and taking the agency out into the community. They value families' ethnic and cultural heritage, which is often reflected in their staffing. As much as possible, they follow a no-reject, no-eject principle promoting safety, stability, and treatment continuity for each child.

Earlier, I noted that one of the three things we want for our children is that every child should have someone to love who loves them back. The best child welfare programs understand that no child should leave residential care or other forms of foster care without permanent connections—without at least one person who is totally committed to his or her well-being.

The young people who arrive at the bottom of the system, as currently envisioned, may not be easy to love. Their parents may be "character builders," but somebody has to love them, and the more people the better.

If you are familiar with *The Gus Chronicles*, you know that Charlie Appelstein invented Gus Studelmeyer as a stand-in for kids in care everywhere, and he uses him to help workers and administrators see our system from the kids' point of view. Gus compares being separated from family to having an arm taken away. Every day in the mirror you see a hole where your arm used to be. Seeing other kids with two arms makes you angry and resentful.

The best child welfare programs understand that no child should leave residential care or other forms of foster care without permanent connections—without at least one person who is totally committed to his or her well-being.

Gus describes how "you become so obsessed with getting your arm back that you forget how painful it was when it was attached." You might be fitted with a new arm, and everyone around you may think it's wonderful, but it doesn't feel like your own. Eventually, you find the one you were born with, and the pain of a dysfunctional family begins again.

If we can avoid radical surgery—which can't always be done—families can heal together over time, or non-family members can fill family roles.

Berisha Black is a young California woman who was in foster care for 15 years, and who copresented a workshop at our recent National Conference. Everybody needs "a whole embrace" of people who care, she said. The first person who offered her a permanent connection that she accepted was the woman she now calls her grandmother. She came into Berisha's life when she was almost 18 and angry.

Berisha said, with a kind of quiet amazement, "She loved the mess out of me." Later, with her adopted grandmother's support, Berisha reconnected with her biological father.

It's never too late to become "somebody's someone," according to Regina Louise, another California foster care graduate who wrote a book by that title. She also wowed the crowd at our conference by telling us how she reconnected with a foster mother who had loved her as a teenager, and being officially adopted when she was past 40. Sooner is better, but it's never too late!

Assessment

I spoke earlier about the artistry and array of tools necessary to shape top-quality services. Assessment tools are among the most important items in our toolbox and need to be employed first. An open-minded, sophisticated assessment of each individual young person should determine the right level of services and the delivery setting along the horizontal continuum for each child.

Monitoring progress in an individualized care and treatment plan should indicate what is working before things go terribly wrong, both on the level of the individual child and on the program level. Based on the individual needs of unique children and youth, a residential setting's controlled environment may be best for initial and ongoing assessments, and may be a good reason not to wait until all else has failed to employ it.

Meaningful assessment leads to decisions in three dimensions: supervision, treatment, and child development.

- Supervision criteria determine what setting is best-suited to protect and nurture the child and support his or her development, and protect staff.
- Treatment needs, including medical, mental health, substance abuse, and behavioral requirements, are a matter for clinical assessment, and require reviewing the child's history, as well as his

or her present issues.
- Developmental assessment captures external and internal competencies.

All three dimensions should be assessed for the family system as well as the child. Assessments and outcome measures should take account of and to be meaningful to the family. They should be long-term to yield useful data. Residential care, like all interventions, should be part of a long-term, continuous strategy of family stabilization in which past, present, and future choices are interrelated.

Ideally, measures are standardized and designed to be shared across systems in a community partnership in which foster care and residential care service providers, referral agencies, funders, public schools, in- and outpatient mental health providers, and juvenile justice agencies plan and deliver services together.

The Crittenton Center in Los Angeles, a CWLA residential agency, reports a success story in which assessment was key. When a young woman they call Laurie arrived at Crittenton three years ago, she was an angry, belligerent, frightened mother of a 2-day-old baby. Social workers were not sure they could reach her.

Though the calm milieu and skilled staff did their work, assessment revealed she had a specific learning disability and was stuck at about a fourth-grade academic level. Her attitude was largely a mask for the frustration she had experienced in school. Using the precise remediation instruments available to them, the agency developed an individual education plan involving hours of one-on-one tutoring.

Once we have assessed a child's and family's strengths and needs and determined a residential setting is the right placement, our challenge is matching the treatment, as well as the environment, to the needs.

Exhilarated by her first taste of success, Laurie devoted hours to study, while learning to parent her small daughter. The agency smoothed the way for her to return to high school. Since graduating, she is living and working on her own, her daughter is safe and happy, and the Crittenton Center is continuing to monitor their progress. This is just one success story among many. We don't hear or tell these kinds of stories nearly enough.

Treatment Modalities

Once we have assessed a child's and family's strengths and needs and determined a residential setting is the right placement, our challenge is matching the treatment, as well as the environment, to the needs. As you know, residential facilities cover a broad span. I could easily give you a list as long as the previous one, including short-term diagnostic care, secure treatment, detention, and supervised transitional living. What's more, definitions vary state to state.

Some state agencies indicate on surveys they have no children in residential care because they call their facilities group homes and they don't include group homes in the definition of residential care. CWLA, through its National Resource Center for Child Welfare Data and Technology, and its National Data Analysis System, is working with state agencies and the Children's Bureau on this issue. It's a slow process.

Sometimes states use the same terms to denote different things. In most states, however, the service array is less than optimal. Skilled workers may use exquisite standardized instruments to determine precisely what is needed and then not be able to provide it. It's no wonder many get discouraged and leave when they experience slot-driven placements and a system with little capacity.

To avoid discouragement, we need to join together in advocating for a full array of services. We have to win over the public, our lawmakers, the corporate sector, and everyone else who can potentially be part of the solution. Even in these hard times, we can point to communities that have found creative ways to fund comprehensive service networks, and we can muster economic arguments to show their long-term cost-effectiveness. Most of all, we must emphasize the least restrictive, appropriate service to meet the needs of each child and family, investing in time-limited intensive services at the outset if assessment shows this is the best bet for dealing with trauma.

Assessment is the way we understand the uniqueness of each child and family. Matching identified needs and strengths with the best possible interventions is how we demonstrate our respect for that uniqueness. Earlier, I talked about a horizontal continuum that serves us much better than a vertical one. In fact, we really need a dynamic model that is flexible and non-linear, like healthy young people themselves. Human development is not a strictly linear process.

To avoid discouragement, we need to join together in advocating for a full array of services. We have to win over the public, our lawmakers, the corporate sector, and everyone else who can potentially be part of the solution.

For example, earlier I listed family preservation near the beginning of the continuum and residential care toward the middle. But who says a family has not been preserved when a child is in appropriate, family-centered residential care? A dynamic model has room for simultaneous interventions, not just sequential ones. The wraparound model does that, and so does multisystemic therapy.

The test of a good program is not what happens in the 5 or 10 months the child is in treatment, but what happens in the 50 or 60 years he or she is outside of it. The more permeable we can make the boundaries between institution and community—while preserving the unique strengths of the institution—the better the outcomes for individuals, families, and society.

Aftercare

Outcome assessment follows from the

initial assessment and continues after the child leaves placement. This brings me to the fourth element of success: aftercare.

What we see clearly when visualizing our interventions on a horizontal axis is the importance of the start and end points: both prevention and early intervention and aftercare. In some cases, decreased funding and shorter stays have had the salutary effect of requiring agencies to begin working intensively with families and community resources as they plan for discharge from the day of admission.

A four-year study reported in the American Journal of Orthopsychiatry (Leichtman, Leichtman, Cornsweet, and Neese 2001) showed significant improvements for young people who stayed in residential treatment just three to four months. This requires a different set of staff attitudes than those of traditional group care, and it means entrances and exits are part of a carefully phased case plan. And, of course, it means families and older youth must play a leading role in planning for the transition and following through during the transition period.

Effective transitions require a healthy, functioning network of community services. Nothing could be further from the old model of residential care that "rescued" children by separating them from their families and their communities.

Today's multi-service agencies are frequently at the hub of a rich network of community connections. Staff members cultivate working relationships and prepare the web of supports each child—or child and family—needs for successful transition back to everyday life. Then they stay involved for at least a year after children exit care.

Taking the agency out into the community is one of the best opportunities for residential care to change its ugly duckling image and avoid discouragement. Successful programs invite the community in for educational programs and festivals. They send young people out into the community as volunteers, as well as to attend school and take advantage of cultural and recreational activities. The last thing a modern residential agency wants is to be seen as that creepy fortress up on the hill.

The Indiana Association of Research Child Care Agencies Outcomes Project, which grew out of a challenge from the Indiana Council of Juvenile and Family Court Judges, tracked 19 of its member agencies with a wide range of services over five years. Youth in residential care were found to have made more gains in several important areas than did those in home-based foster care or shelter care—86.9% had positive educational outcomes at discharge, and 86.8% had sustained them a year later.

Just as schools are among the most important partners for child and family success, universities are key partners for agencies. As permanent, established institutions that command a high degree of respect, you are vital members of any community collaboration. You have numerous opportunities to advance the level of professionalism in the field and to bring research to bear on both practice and public policy.

Agencies may need your help to improve research designs, for example, through the more frequent use of standard measures and comparison groups, and by assisting in statistical analysis. Future research should clearly specify program features and isolate which treatment variables produce positive outcomes that are sustained when youth return to their communities.

The challenges for residential care are many. I mentioned earlier a funding and policy environment threatening our services for children and families, while increasing stressors that tend to fracture families. The devil's toolbox is full. But, as I said, I still have hope. We cannot afford to succumb to discouragement.

So what position should we advocate as we make our case for a full range of services? I want to share language from a position statement CWLA has drafted with tremendous input from our member agencies and others in the field. I will share only a few of the most relevant excerpts reflecting much of what I have presented. They are broken down into the following action steps around policy and service delivery:

Policy

- Conduct initial and ongoing coordinated assessments where the operative question is not, "Where does the child and the family fit into the system," but rather, "Which services in the system best fit the child's and the family's strengths, needs, and permanency plan at the time?"
- Promote the choice of the most appropriate and least restrictive service for children and families, investing in time-limited intensive interventions at the outset and throughout the course of care, if assessment dictates this is the best choice for dealing with trauma or keeping families together.
- Revise policy and practice to acknowledge that some children and families will require services at various levels of intensity over time, and that this may be a decidedly nonlinear process.
- Retain an emphasis on family empowerment and family connections at all levels of service, while recognizing that optimum connections may not mean every parent and child lives together full-time, or without ongoing support.
- Ensure the provision of care and support to families after they receive intensive services, prevent ing future interventions.
- Blend services so there are step-up, step-down, and wraparound options at all levels of intervention, and so boundaries between home-based and out-of-home services are eliminated.
- Develop outcome measures, including cost-benefit measures, not limited solely to discrete services but also related to long-range family stabilization and the real cost of services across time.
- Develop rate reimbursement methodologies that include all direct and indirect costs of providing quality care, treatment, and services.

Service Delivery

- Implement programs and practices actively supporting family centered services that maintain permanent family connections for all children.
- Develop new, structural partnerships between providers of residential services, referral and fund ing agencies, foster care and post-adoption services, public schools, and inpatient and outpatient mental health providers to allow greater access to services at any point along the continuum.

See RESIDENTIAL, page 8

Family-Centered Practices

by Rodger McDaniel and Brenden McKinney

There is a poignant cartoon featuring proverbial chickens separated by a road. The chicken on the one side shouts to the other, "How does a chicken get to the other side of the road?" His counterpart replies, "I am already there!"

This was the common refrain when the Wyoming Department of Family Services (DFS) began implementing family-centered practices two years ago in response to the Child and Family Services Review (CFSR).

When told it was moving to family-centered practices, nearly all DFS staff responded positively, saying, "That is what we've been doing for years," or, similar to the chicken's words,"We're already there."

As I read the 81-page CFSR, it became obvious our Program Improvement Plan (PIP) had to be inclusive of the myriad partners we have in child welfare, both public and private. We have actively involved them in the process, first agreeing on the role of DFS, which is to ensure certain families have the tools and support to raise their own children, and that communities are encouraged to take responsibility for their own families.

Although we understood the DFS had a responsibility to do its job better, we also recognized that even if we did it perfectly, we were one of many players, and, as much as possible, all players had to be on the same page if the system was to change and meet the goals of the CFSR.

The PIP developed fundamentally around this objective, offering a range of initiatives inviting parents and the community to take more responsibility for the welfare of families, even as its specific goals were used to drive an improvement in DFS's practices.

Perhaps the most exciting was developing a common understanding that ultimate success would be found in changing systems. The Casey Family Program was a key player, loaning its Wyoming division director to DFS for the two-year PIP implementation period. Brenden McKinney brought considerable knowledge and resources from Casey, adding credibility and affirmation to many of our efforts.

The cornerstone of the Wyoming effort is Family Partnerships. Working with the governor and other human service agency directors, a decision was made to shift to family-centered practice across agency lines. To institutionalize the new approach, Wyoming trained caseworkers in child welfare, as well as personnel in the areas of probation and parole, mental health and substance abuse, education, and other areas, to use Family Partnership Teams as the basis for working with families, regardless of where they entered the system.

Using a process similar to family decisionmaking, all human service agencies share a common practice—developing a unified case plan, with the family driving the result. Families sit together at the table with the professionals and their community support system. At times, parents, relatives, friends, church members, teachers, neighbors, and others are included.

The plan starts with the strengths of the family and concludes with the buy-in and acceptance of every participant sharing responsibility for the family's success. This process converts the phrase *family-centered practice* into practice. In other words, the chicken actually moves to the other side of the road.

Truly shifting the paradigm isn't simple. It requires an honest review so long-time child welfare staff recognize the difference between what they've done for years and what is meant by *family-centered practice*. In training DFS staff, it became clear that, not unlike the parable of the elephant and the six blind men, we were using the same words to describe entirely different practices. We accomplish this review internally with a quality-assurance protocol and, with our partners, through the key providers' active cooperation.

An important provider group, Wyoming Youth Services Association (WYSA) led the way. WYSA is a professional organization representing nonprofit group homes and residential treatment facilities in Wyoming. These folks, who are worth commending, saw the same need, obtained a grant from the Daniels Fund, and undertook a facility-by-facility review of their current practices, receiving recommendations from a CWLA review about how to get in sync with the department's new direction.

The public system relies heavily on a good relationship with nonprofit facilities, and successfully implementing the PIP required this cooperation and common approach.

We also need a shift in our own thinking. Truly delivering family-centered practices meant an internal self-examination of our worldview: Why are people poor? Why are the people we serve in the system? How caseworkers answer these questions determines their ability to effectively deliver services.

With Casey Family Program's help, we are training all administrators, managers, supervisors, and line workers, as well as key community partners and even client families over three years. Called "Undoing Racism," the training allows individuals and the group to open an honest dialogue, not only about the effect of race, but also about socioeconomic differences and how long-held beliefs about others play a role in service delivery.

How's it all working? We are using a "mini-CFSR" quality-assurance examination to see if the practice is actually changing. We think it is. DFS staff, WYSA, and other partners have

FAMILY, from page 7

undertaken considerable training over the last year. Change is hard. How'd the chicken get to the other side of the road? The answer is, "Slowly."

We are reminded of Elaine Ryan's statement to Congress on the CFSR process. The Congressional Liaison for the American Public Human Services Association, Ryan explained to a congressional committee about how hard the states have worked to improve services:"Most of the states are now too pooped to PIP!"

We are, but the data is showing it's all making a difference, and there's no other reason to be in this business.

Rodger McDaniel is Director of the Wyoming Department of Family Services, Cheyenne.

Brenden McKinney is Executive Director, Wyoming Division, Casey Family Programs, and Assistant Deputy for Systems Improvement, Wyoming Department of Family Services.

RESIDENTIAL, from page 6

- Increase capacity to provide services to children and families with the most intensive needs.
- Commit resources to post-discharge continuity of care and provision of family supports for at least one year after children exit residential programs.
- Develop more flexible methods of providing services throughout residential placement, with greater presence in family homes, local schools, and locations where community-based services are provided.
- Develop universal outcome measures to assess the effective ness of residential services, including in the areas of clinical, functional, and placement effectiveness, and consumer satisfaction.

These steps present significant challenges, made more difficult by taking them on at a time of great adversity. In this regard, I share with you an old Asian saying: when fate throws a dagger at you, there are only two ways to catch it—either by the blade or by the handle.

I believe we can catch the dagger of adversity by the handle and turn a potential moment of crisis into an opportunity to emerge stronger for the sake of our children.

References

Beinecke, R.H. (1999). *Children and youth in Massachusetts residential treatment centers: Who they are and recommendations for improving the quality of care: A survey of Massachusetts children's residential treatment providers*. Boston: Suffolk University Department of Public Management for the Children's League of Massachusetts, Inc.

Blackman, M., Eustace, J., & Chowdhury, M.A. (1991). Adolescent residential treatment: A one to three year follow-up. *Canadian Journal of Psychiatry*, *36*, 472–479.

Children's Bureau. (2005). *Child welfare reviews*. Available online at www.acf.hhs.gov/programs/cb/cwrp/index.htm. Washington, DC: U.S. Department of Health and Human Services.

Leichtman, M., Leichtman, M.L., Cornsweet, C., & Neese, D.T. (2001, April). Effectiveness of intensive short-term residential treatment with severely disturbed adolescents. *American Journal of Orthopsychiatry, 71*(2), 227–235.

Marsenich, L., & Meezan, W. (2004). *Towards rationalizing outcome measures in residential care for children*. Manuscript submitted to Research on Social Work Practice.

Weiner, A., & Kupermintz, H. (2001). Facing adulthood alone: The long-term impact of family break-up and infant institutions: A longitudinal study. *British Journal of Social Work, 31*(2), 213–234.

Q: Can the Community Serve Sex Offenders?

POINT: Sex offenders require a level of intensity best provided within campus-based or self-contained programs.

by Daniel Wallach

The nightmare of child sexual abuse, once suppressed and denied, has been jettisoned into our awareness through media accounts indicting celebrities and even priests. While this reveals the problem's widespread nature, it is far more difficult to chronicle the pain, shame, and sadness experienced by young victims and their family. When the abuser is also a child or adolescent, the experience of parents can be similarly heartbreaking, further magnified if the victim and abuser are both their offspring.

This scenario of intrafamilial abuse can place parents in the double bind of protecting their child, while having to "cast away" their other progeny. Although community safety is the foremost consideration in treating adult offenders, what factors guide our approach to children who abuse?

We all agree that children with sexual behavior problems need and may benefit, by virtue of their age, from treatment. Also, few argue that community safety is anything but a critical consideration. When both the victims and perpetrators of sexual abuse are children, it is very important to meld protecting the community and helping the sexually aggressive child to change. Because of this dual focus, most juvenile abusers are best treated, initially, in a residential treatment center.

Proponents of treating this population in community settings cite the benefits of continued ties with the home community, normalization, and using the least restrictive intervention possible. All of these arguments bear elements of validity. I believe, however, the importance of these factors is progressive, gaining importance as a youngster advances in treatment and prepares to return to the community at large.

Advocates for the community model also note not all children who have acted out sexually pose an ongoing threat. This is true, but even our best methods for assessing risk do not give us foolproof tools to absolutely determine who is safe. Unfortunately, certain circumstances compel the drastic intervention of removing a child from the community temporarily.

Community Safety

Simply put, before completing diagnostic and assessment work, the risk of repeating similar behavior is unknown. There are cases in which an act determined to be abusive is an isolated

See POINT, page 10

COUNTERPOINT: Home and community-based settings can effectively treat sex offenders.

by Wayne D. Parks, MA, CFC, DAPA

Twenty years ago, a large body of research on effectively treating adolescent sex offenders simply wasn't available. Empirically validated assessment protocols for this population were essentially nonexistent. The treatment community was forced to look at adolescents as smaller versions of adult offenders.

At the time, the paradigm suggested young offenders required placement in secure facilities, primarily for the community's protection. Once a sex offender, always a sex offender, was the belief. Consequently, treating clinicians adopted the same treatment approach used for adults. This approach, adapted from the alcohol and substance abuse model, was 12-step-oriented and coupled with cognitive behavioral and group dynamic treatment.

Over the past 20 years, as clinicians such as Faye Honey Knopp, John Hunter, Jonathan Ross, and Kenneth Loss provided clinicians with a more precise clinical basis for working with this population, the treatment paradigm shifted. The treating community became increasingly aware of substantive clinical differences between adult and juvenile offenders. The adolescent population, though not lacking unique challenges, presented an encouraging short-term, as well as long-term, positive prognosis.

During this 20-year shift in the treatment paradigm, much research seems to substantiate theories about the significant effect of early childhood trauma on child or adolescent sex offenders. As emerging empirical evidence has identified the connecting thread between childhood victims of emotional, physical, and sexual abuse—and antisocial, acting-out sexually abusive behaviors—clinical and community support services have started considering the etiology of these behaviors. It's become apparent that inappropriate juvenile sexual behaviors may be more symptomatic of post traumatic stress disorder (PTSD), a diagnosis that requires augmenting traditional sex offender treatments with specific PTSD clinical interventions.

M. J. Horowitz (1986), in his studies of stress response syndromes, suggests clients will continue to reenact original trauma until it is therapeutically worked through; further, self-destructive reenactments may feel good cognitively. The act may medicate the emotional pain of the original trauma. Sex

See COUNTERPOINT, page 11

POINT, from page 9

behavior, born of circumstances likely not repeated.

Not infrequently, however, does a child engage in treatment and disclose additional transgressions—sometimes extensively. For some youth, abusive behavior has become compulsive and fixated. Additionally, variables related to the abusive act(s) may affect safety, such as the use of coercion, force, or even weapons. Thus, elements of violence involved in an offense, and the extent of the youth's sexually aggressive behavior, are both relevant to the level of risk to others.

Community safety and the child's best interests in treatment are not mutually exclusive concepts. In fact, the reduction of opportunities to reoffend while in treatment protects the abuser, as well as potential targets. A reoccurrence of sexually abusive behavior can result in criminal charges, additional turmoil for the family, further damage to the child's self concept, and decreased likelihood of successful healing.

Assessment and Diagnosis

It is reasonable to presume some juveniles can be treated in open community settings with minimal risk.

Treatment programs for this population use a variety of tools and protocols to assess the risk of reoffending. Even the best tools, however, only project probability; none are statistically validated. Potential damage to future sexual abuse victims makes the stakes unacceptably high.

Assessing a child's critical needs in treatment requires gathering historical information and assessing individual strengths, available resources, and factors related to the abuse.

Direct observation is another layer to assessment, augmenting the depth of the data that inform treatment direction. Residential programs provide opportunities to observe patterns of behavior, including sexual behavior; interactions and relationships; individual aptitudes; cognitive models; and other relevant considerations.

Treatment

Perhaps the most significant single benefit of an initial residential placement is preventing further inappropriate sexual behavior. Because sex is typically self-reinforcing, stopping this cycle reduces the likelihood of fixation.

Residential programs properly equipped to handle this population have staffing and resources that allow effective monitoring and interventions. Even effective group and foster homes cannot provide the level of supervision of a well-staffed residential program.

The benefits of normalization for children in treatment may be more appropriate at later stages. It makes sense to bolster this because client attitude, including motivation, may be the largest correlate to treatment success. Yet youth, with their sense of invulnerability and general immaturity, are often difficult to motivate. The drastic effect of removal from home and community may accentuate the seriousness of the situation and consequently motivate the child to work to go home or to a more open setting.

It is reasonable to presume some juveniles can be treated in open community settings with minimal risk.

Motivation for sexual abuse is often founded in interpersonal dynamics rather than the experience of sex, and may be seen as a relational disturbance. Thus, integral to treatment is helping the child learn to seek, experience, and maintain healthy relationships. Again, the residential center's ability to limit and control variables may provide a virtual learning laboratory for relating.

Treating sexual behavior problems also hinges on mediating comorbid conditions that exacerbate or may contribute to these issues. Treatment centers provide easier access to services, including psychiatry, medical assistance, educational testing and assistance, therapeutic recreation, and other support.

Though this assistance is available in the community, coordinating these services is rarely equal to those found in campus settings.

Child and Family Factors

Juvenile offenders frequently hurt younger children, often siblings or other relatives. These victims need their own treatment, a process arguably hindered if the abuser is in the home or community. They also need to hear that adults take their mistreatment seriously and hold the abuser solely responsible, which can plant the seed with the abuser for victim empathy.

Summary:

Juveniles who have sexually offended can potentially cause great harm to others despite their youth. Though the field recognizes variation in relative risk, assessment is not fullproof.

Consequently, a key treatment goal must be the protection of community safety (NAPN, 1993). Additionally, interfering with this sexual behavior is essential to impeding further psychosexual problems (Becker and Hunter, 1997). Teaching children to relate to others in an appropriate manner is also a primary treatment task. Highly structured interventions are recommended for this work (Morenz & Becker, 1995), thus the residential treatment center has clear advantages in assessment and initial treatment stages.

Though treatment in the community has merits, it should be considered a step down from structured residential treatment for most young sexual abusers. To best address the needs of juveniles who have committed sex offenses, and the needs of the community, a continuum of care is recommended, (Bengis, 1997; NAPN, 1993).

Perils posed by treatment failure for youth whose recidivism risk is initially unclear lends credence to the argument for temporarily providing structure and containment inherent in staff-secure (or in some cases structurally secure) residential treatment programs.

See POINT, page 11

POINT, from page 10

References

Becker, J.V., & Hunter, J.A. (1997). Understanding and treating child and adolescent sexual offenders. In T.H. Ollendick & R.J. Prinz (Eds.), *Advances in clinical child psychology* (19). New York: Plenum Press.

Bengis, S. (1997). Comprehensive service delivery with a continuum of care. In G.D. Ryan & S.L. Lane (Eds.), *Juvenile sexual offending: causes, consequences, and correction* (pp. 211–218). San Francisco: Jossey-Bass Publishers.

National Adolescent Perpetrator Network (NAPN). (1993). The revised report from the National Task Force on Juvenile Sexual Offending. *Juvenile and Family Court Journal*, *44*(4), 1–120.

Morenz, B., & Becker, J.V. (1995). The treatment of youthful sexual offenders. *Applied and Preventive Psychology*, *4*(4), 247–256.

Daniel Wallach is the Director of the Sexually Reactive Unit at the Stetson School, Inc., Barre, Massachusetts.

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

Question:

Are behavior support and intervention training programs the answer to reducing and eventually eliminating the use of restraints and seclusion?

Point:

By using one of the nationally recognized behavior support and intervention training programs, an organization can significantly reduced its reliance on restraint and seclusion.

Counterpoint:

An effective behavior support and training program is only one component within the comprehensive approach needed to reduce and eventually eliminate restraint and seclusion. A number of other approaches must be implemented to reduce and sustain an agency's nonreliance on these emergency procedures.

COUNTERPOINT, from page 9

offending behavior often appears as an effort to externalize feelings of pain, fear, and anger.

Clinicians specializing in treating adult sex offenders have long lamented that if adult offenders had received significant clinical intervention at an early age, their disorders and accompanying destructive behaviors could have been averted. Clearly, adolescent sex offender treatment represents this level of early intervention. Successful intervention, however, must be comprehensive.

If adolescent sex offending behavior is a direct response to childhood trauma, then acting-out behavior is also symptomatic of a family-systems failure. In addition, therefore, to general sex offender treatment combined with clinically indicated PTSD treatment, an aggressive family systems treatment intervention becomes imperative.

Since a family's wraparound support resources are found in the community, removing the child or adolescent from community support may be counter indicated. Placing a low- or moderate-risk juvenile sex offender in a secure, controlled environment may accomplish several treatment objectives. This still leaves the substantive work unaffected (including family systems, real-world implementation of this new life program, and development of appropriate social skills). In a controlled environment, we are severely restricted from any realistic effort to impact the etiology of the deviant behavior's source.

In community-based treatment model, clinical staff have found success using an integrated treatment model that combines several approaches. Clinicians responsible for center-based individual and group therapy components use the cognitive-behavioral and PTSD/Abreaction model.

The primary goal of abreaction therapy, according to Mark Schwartz (et. al., 1992), is empowering and reclaiming control over one's life by stopping revictimization due to early trauma—coded adaptation. In the community-based model, home-based family therapists use a combined family systems and relapse prevention model. The relapse prevention approach, advanced by Pithers (et. al., 1987, 1988), is designed to increase the client's awareness and range of choices concerning his behavior, to help the client develop specific coping skills and self-control capacities, and to help the client create a general sense of mastery or control over his life.

A major component of community-based relapse prevention models is the external supervisory element, which increases the efficiency of this approach by creating an informed network of collateral contacts that can help monitor a client's behavior. Contacts include family members, school staff, probation counselors, mental health providers, and others in the community. The home-based family therapist facilitates constant information exchange throughout the collateral contact network.

This integrative treatment model, referenced in Barbara Schwartz's study of effective treatment techniques for sex offenses (1992), responds to the client's individual complexity. It recognizes acting-out or exhibited behavior as a complex combination of physiological, cognitive, affective, social, cultural, and even spiritual issues. Successful treatment approaches must be as multifaceted as the condition.

References

Horowitz, M.J. (1986) *Stress response syndromes: A review of post-traumatic and adjustment disorders*. New York: Jason Aronson.

Pithers, W., Cumming, G., Beal, L., Young, W., & Turner, R. (1987, 1988) Can relapse be prevented? Initial outcomes data from the Vermont treatment program for sexual aggressors. In D.R. Laws (Ed). *Relapse prevention with sex offenders*. (pp. 313-325). New York: The Guilford Press.

Schwartz, B. (1992) Effective treatment techniques for sex offenders. *Psychiatric Annals, 22:6,* 315.

Schwartz, M. (1992) Sexual compulsivity as post trauma stress disorder: Treatment perspective. *Psychiatric Annals, 22:6*, 333.

Wayne Parks is Director of Family Trauma Services, Inc. in Alexandria, Virginia.