RESIDENTIAL
GROUP CARE QUARTERLY

VOLUME 7, NUMBER 1 CHILD WELFARE LEAGUE OF AMERICA SUMMER 2006

Building Bridges Between Service Delivery Providers, Families, and Youth

Reported by Lloyd Bullard

The Substance Abuse and Mental Health Services Administration (SAMHSA) held the Building Bridges Summit June 14–17, 2006. The summit's intent was to better integrate and link residential and community services and support, thereby creating a clearer picture of the role residential care plays in a continuum of services.

Gary M. Blau, Chief of SAMHSA's Child, Adolescent, and Family Branch, Center for Mental Health Services, spearheaded the event. Participants included residential and community-based service providers, leaders from national organizations, and youth and family leaders.

I participated in the summit's planning and development, along with CWLA's President and CEO Shay Bilchik. A number of CWLA's public and private member agency representatives also participated. (See the list of invitees, page 4)

Following is the meeting outcome statement and preliminary draft of the joint resolution of common purpose, shared principles, values, and practices.

Meeting Outcomes Statement
A group of leaders in children's mental health met in Omaha, Nebraska, June 14–17, 2006, to better integrate and link residential (out-of-home) and community services and supports. Participants in this summit included residential and community-based service providers, leaders from national organizations, and youth and family leaders.

The group engaged in extensive dialogue, learned from each other's perspectives and experiences, and ultimately developed a joint resolution of common purpose, shared principles, values, and practices. The joint resolution envisions a comprehensive, family-driven, and youth-guided array of culturally competent and community-based serv-ices and supports, organized in an integrated system in which families, youth, providers, advocates, and policymakers share responsibility and accountability for the care and treatment of children and youth with mental health needs and their families.

The meeting and the joint resolution represent a new level of unity, partnership, and collaboration among these constituencies. Group members will work to finalize the consensus document during summer 2006. The group also agreed to develop a multi-faceted

INSIDE

Progress on the North American Certification Project
The North American Certification Project arose from a broad opinion that North American certification for child and youth care practitioners is urgently needed.
—Page 8

Preventing Violence in Residential Care
Action at all levels of a public health model is necessary to tackle the problem of violence.
—Page 11

The Teaching Family Model in Day Treatment Programs
Barium Springs Home for Children decreased restrictive interventions by using the Teaching Family Model technology.
—Page 14

Point/Counterpoint
Should states include structural/institutional racism as a factor in how they mitigate racial disproportionality and disparity of outcomes?
—Page 17

RESIDENTIAL GROUP CARE QUARTERLY

Volume 7, Number 1

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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.

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strategy to promote the implementation of the joint resolution in policy and practice nationwide. This activity is evidence of important, critical new partnerships and demonstrates a strong commitment to transforming children's mental health in America.

Joint Resolution to Advance a Statement of Shared Core Principles (preliminary draft, June 30, 2006)

Preamble

An exciting and significant step toward transforming the children's mental health system occurred at the recent Building Bridges Summit in Omaha, Nebraska, June 14–17, 2006. To address historical tensions between residential and community-based service providers and systems, a group of leaders in children's mental health met to better integrate and link residential (out-of-home) and community services and supports.

Chosen because of their range of experience and depth of knowledge, as well as their personal commitment to ensuring services that are respectful, empowering, and effective, summit participants included residential and community-service providers, family members, youth, national and state policymakers, system of care council members, tribal representatives, and representatives of national associations related to children's mental health and residential care.

The purpose of the summit was to:

- Establish defined areas of consensus related to values, philosophies, and services.
- Develop a joint statement about the importance of creating a comprehensive service array for children, youth, and families, inclusive of residential and out-of-home treatment settings as part of the entire range of services.
- Identify emerging best practices in linking residential and community services.
- Set the stage for strengthening relationships and promoting consensus building.
- Create action steps for the future.

To a large degree, the summit accomplished these goals. Participants were able to dialogue and learn from each other's perspectives and experiences. Presentations highlighted positive outcomes from integrating residential and system of care services. The youth and family voice was powerful and

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provided leadership in helping to establish the emerging vision.

A particular accomplishment was the development of a joint resolution of common purpose, shared principles, values, and practices. The resolution identifies an urgent need for transformation and envisions a comprehensive, family-driven, youth-guided array of culturally competent and community-based services and supports, organized in an integrated system in which families, youth, providers, advocates, and policymakers share responsibility and accountability for the care and treatment of children and youth with mental health needs and their families.

Participants believe that actualizing this vision will yield a more efficient service delivery system; more effective and appropriate services to children, youth and families; better use of resources; and improved outcomes.

The meeting and joint resolution represent a new level of unity, partnership, and collaboration among the constituencies. The group agreed to develop a multifaceted strategy to promote the implementation of the joint resolution in policy and practice nationwide. Meeting participants hope that the principles, values, and practices will be adopted and implemented by organizations, local communities, state and national associations, states, and the federal government. The summit and follow-up plans are evidence of important, critical new partnerships and demonstrate a strong commitment to transforming children's mental health care in the United States.

Resolution

Whereas—Children, youth, and families should live a full life, where they experience love, joy, learning, health, hope, and safety, and are able to reach their full potential;

Whereas—Children, youth, and families should have access to a comprehensive array of appropriate mental health services that includes promotion and prevention, early intervention, and community-based services and supports, including settings that provide 24-hour treatment, and both short- and long-term care;

Whereas—Children and youth who have mental health needs, and their families, are often served by other child-serving systems, including child welfare, substance abuse, juvenile justice, education, health and developmental disabilities; and

Whereas—There is a sense of urgency to transform and improve mental health service delivery because children, youth, and families deserve to have their mental health needs addressed now.

Be it therefore now resolved that the undersigned agree to establish a partnership and a commitment to a core set of principles. Further, we agree to follow these principles and practices in our work and daily lives and to promote them in our activities.

Specifically, we agree to:

Core Values

- Demonstrate, in word and deed, the utmost respect for children, youth, and families and one another, and create an environment that values cultural differences, listening, and learning from each other.
- Create approaches to ensure that no family has to relinquish custody of their child to obtain mental health services, and that mental health parity is recognized.
- Espouse a model for 24-hour treatment that is multiservice; takes a holistic view of each child, youth, and family, incorporating physical health, spiritual health, intellectual pursuits, social engagement, and emotional health; and creates access to a broad array of services and supports.
- Commit to developing or enhancing community-based services that are necessary to decrease the need for 24-hour treatment settings or that facilitate the transition from 24-hour treatment to community-based service settings.
- Recognize the value of relationship-based approaches, and use them in all aspects of care.

Family-Driven and Youth-Guided

- Create and advance a philosophy that the commitment to a child, youth, and family is ongoing, does not allow for a premature discharge, strives to provide long-term continuity, supports transitions, and incorporates a "whatever it takes" and "never give up" attitude to providing help and support.
- Embrace the concept of family-driven, youth-guided care so youth and families are integral partners in service-delivery decisions and agency functioning, including having roles of significance on agency boards and committees.
- Ensure children, youth, and families feel safe and nurtured and have a sense of belonging, and that children and youth have a developmentally appropriate role in their care and in creating rules, regulations, and policies.
- Ensure sibling bonds are maintained and that assistance to siblings is incorporated into treatment plans as indicated.
- Commit to finding ways to ensure that children and youth grow up in families. If a youth requires treatment in a 24-hour treatment setting, this should occur only for a period of time that is necessary, and, for whatever period of time, it is understood this represents a young person's home, and there is a need to create a home-like environment in which activities are "normalized" and family members have open access to the facility.

Cultural and Linguistic Competence

- Develop plans and implement services that value culture, spirituality and religion and provide opportunities for children, youth, and families to use their native languages and indigenous healing practices.
- Develop strategies to reduce the overrepresentation of children of color in both restrictive and nonrestrictive settings, and the disparity in outcomes.

Clinical Excellence and Quality Standards

- Provide the highest quality of care

that is based on clinical excellence, is trauma informed, uses the latest research evidence, and emphasizes continuous quality improvement that uses data and feedback to advance the goals of improving services.
- Determine and identify service approaches that are most appropriate for children and youth, what treatment settings should be used, and for how long.
- Develop behavior support techniques that are positive, strive to eliminate coercion and coercive interventions, use only medications that are clinically appropriate, and do not take away basic rights, including visits between families and children.
- Ensure all treatment services are licensed and regulated by appropriate agencies, and that monitoring is accomplished by well-trained individuals (including families and professionals) whose values are consistent with these principles.
- Hold all providers and systems accountable for actions and outcomes. If something doesn't reflect quality, doesn't work, or doesn't embrace the values of the field, it cannot be maintained.

Accessibility and Community Involvement
- Provide services to children and youth within close proximity to families, or provide strategies to ensure distance issues are adequately and appropriately addressed.
- Participate in the local community and with other child-serving agencies to improve coordination and access schools and recreational opportunities, and to create a presence in families, schools, and community providers.

Transition from Youth to Adulthood
- Provide coordination and assistance as a young person transitions to adulthood.
- Ensure transitions to and from 24-hour treatment are addressed as a component of the service model, including the preparation for treatment and coordination with post-treatment discharge.
- Ensure lifeskills practice and training are required in all service-delivery models and that education/vocation services are a critical focus.

Effective Workforce Development
- Ensure the workforce is competent; receives regular, ongoing training and supervision; is well compensated; and reflects the diversity of the population being served.

Assessment, Evaluation, and Continuous Quality Improvement
- Develop universal outcomes that measure the effectiveness of services.
- Obtain and provide the highest quality assessment that drives services so that meaningful individualized plans for every child, youth, and family are developed and implemented, and to ensure these plans include a significant focus on child, youth, and family strengths, and are culturally competent.
- Conduct research and evaluation, including follow-up, post-discharge data collection to determine the effectiveness of services on relevant outcomes such as success in education and work settings, recidivism in mental health and other child serving systems, as well as social connectedness.

In addressing the principles espoused in this joint position, the undersigned recognize the fiscal complexities and realities in providing services. Therefore, we further agree to:
- Commit to working together to identify resources that support the goals, values, and principles in this statement, including strategies to support flexible funds and waivers for home and community-based services (for example, in-home support services, respite care, and mentorship).
- Commit to creating a balance in funding and capacity between community-based services and 24-hour treatment that acknowledges the importance of having a comprehensive array of services and supports and strives to ensure that there are enough resources in the community to promote appropriate placements and facilitates timely discharge.
- Create incentives for community services and supports and 24-hour treatment to rebalance, reallocate, reengineer, and ultimately reinvest in services to allow for youth and family choice, and that focus on effective services that create the most positive outcomes.

Contact the office of Gary M. Blau, PhD, Chief, Child and Adolescent Family Branch, Center for Mental Health Services, at 240/276-1921, or via e-mail at gary.blau@samhsa.hhs.gov, to convey your support or to request additional information.

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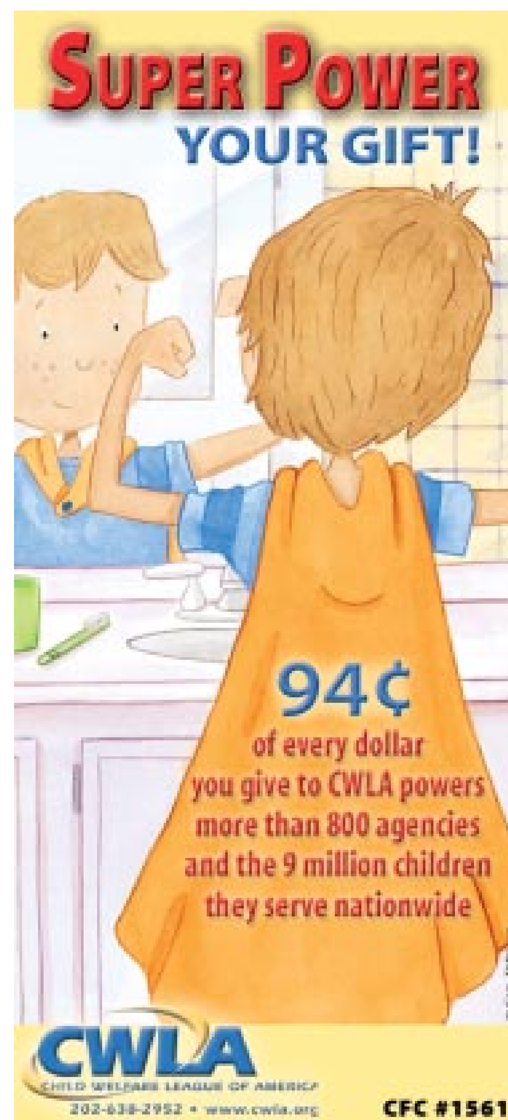

The Promise of Professionalism Arrives in Practice: Progress on the North American Certification Project

By Martha A. Mattingly and David Thomas

In recent years, a workforce crisis has developed in the field of child welfare (Annie E. Casey Foundation, 2003) as workers have become frustrated and felt poorly supported (Light, 2003), leading to high turnover rates (Drais-Parillo, 2002). The fields of child day care or early childhood education (Macdonald & Merrill, 2002), after-school programs (Halpern, 2002), and psychiatric institutions for children and adolescents (American Academy of Child and Adolescent Psychiatry, 2002) face similar issues.

Evidence in the literature suggests these workforce factors also correlate with abuse of children or youth in care (Bednar, 2003), increased use of physical restraint with children and youth in care (American Academy of Child and Adolescent Psychiatry, 2002; Jones & Timbers, 2003), poor client satisfaction with services (Bednar, 2003), and inadequate service quality and outcomes (Bednar, 2003; Halpern, 2002; Macdonald & Merrill, 2002). Savicki (2001) found that a lack of peer cohesion, poor supervisor support, work overload, environmental disorder, and a lack of autonomy, in addition to certain individual personality factors, all correlated with burnout among child and youth care workers. The same study showed that 21% of workers were suffering extreme symptoms of burnout, 62% were classified in a mixed burnout category, and only 17% were classified in the low burnout group.

Lochhead (2001) stressed the chicken and egg nature of many problems in the field. The profession of child and youth care does not have a positive, clear identity, for example, which means there is no strong public support for funding. This also means the system is underfunded and working conditions are dire, resulting in poor training, low standards for workers, and rapid turnover. The quality of practitioners often is not good, which leads to problems that are played up in the press because of the negative image of the field, leading to less positive information and a poorly defined identity for the profession. According to Lochhead, the challenge for leaders in the field is to take practical steps that will break some of these cycles.

For the past 30 years, a group of practitioners, educators, researchers, and theorists in the field of child and youth care have discussed, written about, and organized a profession of child and youth care practice in North America, with the goal of changing some of the underlying factors that have contributed to these chronic problems (Kelly, 1990; Krueger, 2002; Lochhead, 2001; Thomas, 2002). When a profession is firmly established, the benefits to employers can include lower levels of burnout and turnover among direct-care workers. Benefits to children and youth in the systems can include more competent and compassionate care in the context of more stable relationships. Benefits for practitioners include enhanced status, more autonomy and authority, and higher wages.

Although definitions of *profession* vary, and the literature includes evidence of disagreement on the steps to reaching the goal of professionalization, consensus has evolved in recent years on the necessity of a system for certifying that individual child and youth care practitioners meet defined standards for competence. Relatively little has been published in the child and youth care field about the methods for assessing a practitioner's competence. Substantial literature exists in other fields, however, about certification examinations and other methods of assessing professional competence.

The North American Certification Project (NACP; Mattingly et al., 2002) arose from a broad opinion that North American certification for child and youth care practitioners is urgently needed. This project is a joint response by the Association for Child and Youth Care Practice (ACYCP), the Council of Canadian Child and Youth Care Associations (CCCYCA), and the International Leadership Coalition for Professional Child and Youth Care Work (ILC). Formally supporting organizations are: the Academy of Child and Youth Care Professionals, CWLA's Walker-Trieschman Center, ACYCP, the Child Welfare League of America, CCCYCA, ILC, and the National Resource Center for Youth Services.

The project is funded and supported by the efforts of the child and youth care professional community.

Numerous mature child and youth care practitioners and academics from Canada and the United States have provided project leadership, support, materials, and critical comments, all essential to the success of this effort.

The project is guided by the current description of the field and is committed to the principles of inclusion of organizations and persons concerned with setting standards for child and youth care practitioners, credibility, generic standards applicable to the broad array of practice settings,

reciprocity among governmental units and practice settings, and support for the ethical standards of the field. Three levels of certification are probably needed for the full development of the profession: entry level, first professional level (roughly comparable to that of a teacher or social worker), and an advanced level. The North American Certification Project (NACP) currently is focused on developing certification for the first professional level.

This paper reviews the work completed and in process toward establishing the competencies, the proposed certification process, and the design for the assessment of the competencies. The educational system, governmental organizations, and development of professional bodies differs between the United States and Canada. The certification process described here is for the United States; appropriate Canadian bodies and constituencies are attending to this issue for Canada.

Developing the Competencies

For many years, organizations concerned with child and youth care practice have developed statements of standards, most of which are not part of the indexed literature. To develop the NACP

Consensus has evolved in recent years on the necessity of a system for certifying that individual child and youth care practitioners meet defined standards for competence.

competencies document, materials related to practitioner standards and competency in the field were collected, reviewed, and prepared for analysis. Over about five years, a group of child and youth care professionals used these collected documents as a foundation, interpreted their meaning, filled in existing gaps, removed what was not useful, articulated new directions, made the language clear and direct, and established congruence with current scholarship.

Values related to practice were extracted and edited and now appear as the "foundational values for professional child and youth care practice." Four competency domains were identified: professionalism, applied human development, relationship and communication, and developmental practice methods.

An additional domain, cultural and human diversity was added. It is likely that cultural and human diversity did not emerge in the collected literature since many documents are older and the discussion of culture and diversity is a more recent phenomenon. Each domain has a description, a list of foundational knowledge, and a detailed list of competencies.

The developmental, ecological perspective of the field led to a consideration of the competencies in specific contexts of application: self, relationship, environment, organization (system), and culture. Further development of these contextual considerations may be carried out in the future.

The document was edited, posted on the ACYCP website for comment, revised, and then reposted to the web (Mattingly et al., 2002). ACYCP has accepted the document as the basis for professional certification in the United States. It is also being considered by appropriate Canadian bodies.

Proposed Application Process and Requirements for the United States

ACYCP (2002) has outlined six basic requirements for certification as a professional-level child and youth care practitioner. Persons certified through this process can use the title Certified Child and Youth Care Practitioner. The initials CCYCP may be used following the practitioner's name—for example, John W. Smith, BS, CCYCP. To qualify to sit for the examination, candidates have to document their preparation and competence in the first five areas: education, experience, references, training, and professional membership. All six criteria must be met for certification.

Education requirements. At least a baccalaureate degree from a regionally accredited college or university (without specific major) is required. Waivers are available for the first seven years of the certification process (see experience requirements).

For many years, organizations concerned with child and youth care practice have developed statements of standards, most of which are not part of the indexed literature.

Experience requirements are based on paid employment, with the exception of supervised field-related internships, for which a maximum of 500 hours may be applied. Serving as a foster parent qualifies, volunteer work does not. There will also be additional specifications for appropriate experience to relate to the competencies. The degree (experience) ladder is: master's degree, 2,000 hours qualified experience; bachelor's degree, 4,000 hours, and waivers for the first seven years; associate's degree, 6,000 hours; high school or equivalent, 10,000 hours. All experience must be qualified and documented.

Training requirements. Candidates must document 250 hours of training directly related to the competency areas. At least 100 of these training hours must have occurred during the past five years. Candidates must meet the minimum required standards for each of the competency domains: professionalism (20 hours), cultural and human diversity (20 hours), applied human development (20 hours), relationship and communication (40 hours), developmental practice methods (80 hours). Qualified training involves formal agency in-service training, conference and workshops

attendance (for specific sessions attended only), and college-level courses, provided they address the competencies.Certification must be renewed every two years with the completion of 30 hours of qualified continuing education.

Professional references. Four professional references from people who have known the candidate for at least six months are required, including a direct supervisor or a second supervisor or CYC professional, and two references from peers familiar with the applicant's skills and abilities.

Professional membership. Active involvement in the profession is demonstrated by current membership and participation in at least one qualified professional organization related to child and youth care practice.

Assessment of the Competencies

To certify individual practitioners, the national association must first create methods for evaluating knowledge, skills, and abilities in the areas described in the NACP Competencies Document.

As of July 2006, the competencies have been sorted into categories best assessed by examination, portfolio, and supervisor assessment. A competency-based examination based on scenarios collected from the field has been constructed and pilot tested on about 850 practitioners (750 from the United States and 100 from Canada), and validation studies are in progress. A competency-based portfolio and a competency-based supervisor's assessment have also been developed. The first practitioners will be certified within the next few months.

The NACP Assessment Work Group includes Dale Curry, Frank Eckles, John Markoe, Martha Mattingly, Carol Stuart, David Thomas (Coordinator), and Susan Wierzbicki. Additional reviewers and consultants for the group include Lloyd Bullard, Carol Kelly, Tony Maciocia, Varda Mann-Feder, Peter Rosenblatt, and Anne Tubb. Most of the committee's work is conducted through teleconference meetings that have occurred two or three times a month for more than a year. The work group has almost completed the test design for the certification examination after identifying which competencies can best be assessed through each of the different methods.

The use of a certification examination was discussed extensively before the North American Certification Project participants, the ACYCP Board of Directors, and the Assessment Work Group reached a consensus on the necessity for the exam. Concerns expressed by participants about the use of an examination included the difficulties of testing knowledge, skills, and abilities through paper-and-pencil examinations, the challenge of placing the competencies in the context of practice in an exam, and possible adverse effects on minority group members.

With an effective, widely recognized national certification system, individual practitioners will be able to gain recognition for their abilities in a way that translates across settings, states, and nations.

The literature also reflects these concerns (Haladyna, 1994; Peluso, 2000; & Sackett et al., 2001). On the other hand, Sacket et.al. (2001) emphasized the value of well-designed tests and assessment measures with high validity, which virtually all professional certification programs employ for good reason.

Although the challenges are substantial, the outcome should be worthwhile. With an effective, widely recognized national certification system, individual practitioners will be able to gain recognition for their abilities in a way that translates across settings, states, and nations. This is a necessary step for child and youth care on the road to full professional status.

Following are updates on the North American Certification Project:

- The instruments for assessing the candidates, the certification examination, the competency-based portfolio, and the supervisory's assessment tool have been completed.
- A study to validate the certification examination is underway.
- The competency-based portfolio and the supervisory's assessment tool are in review.
- Certification will tentatively be available to the validation test group in early 2007.
- Certification will tentatively be available to qualified candidates in late 2007.

(This article was adapted from an article in the Journal of Child and Youth Care, *Volume 19, 2004.)*

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continued on page 16

Preventing Violence in Residential Care: A Public Health Perspective

By Brodie Paterson, David Leadbetter, and Gail Miller

Violence in child care is an issue that has been framed largely as a problem of individual staff attitudes or skill deficits that are remediable by conflict management or physical intervention skills training. By default, this approach has deemphasized the central role and responsibility of the agency and the structural dimensions of care that lie outside the control of individual workers (Leadbetter & Paterson, 2004).

As such, the individualizing approach represents a potentially catastrophic mistake, albeit one in which the recent history of violence prevention suggests many organizations continue to make (Leadbetter, 2004).

In this context, the prevention of violence needs to be understood from the public health model (Sethi et al., 2004). This suggests prevention has three distinct dimensions (see Figure 1):

- **Primary prevention:** action taken to prevent violence before it happens by addressing root causes.
- **Secondary prevention:** action taken to prevent violence when it is perceived to be imminent.
- **Tertiary prevention:** action taken during and after violence has occurred to prevent or reduce the potential for physical and psychological harm to the parties involved and to inform primary and secondary prevention strategies. The notion of prevention, in this context, is in the public health sense of preventing or reducing harm (Sethi et al., 2004). All levels require
- action at the organization level,
- the staff team,
- the individual worker, and
- the children and young people.

The premise is that each level operates within its own circle of influence (see Figure 2). Action at all levels is necessary if the problem of violence is to be tackled.

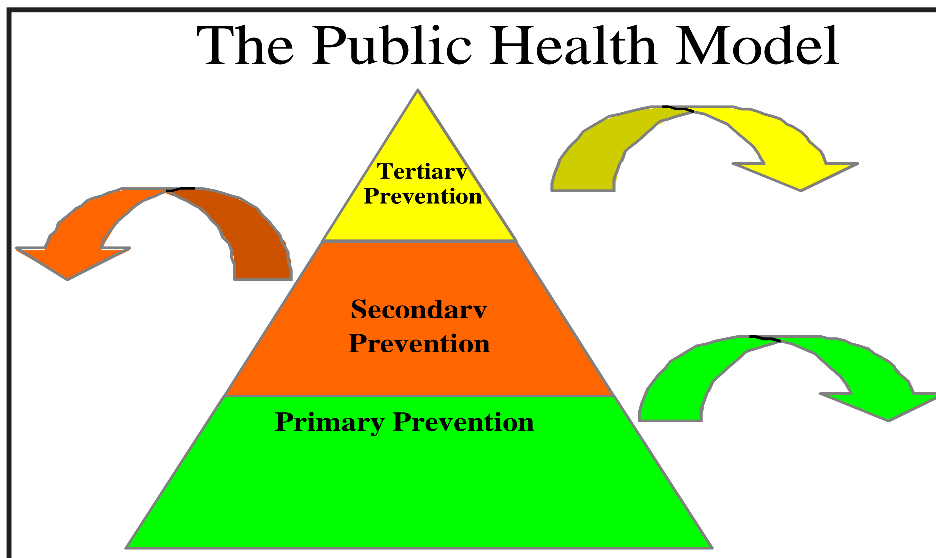

Figure 1

Action at the Organization Level

Violence prevention at an organizational level requires clear leadership via a senior manager with overall responsibility for preventing violence and developing, disseminating, and implementing a policy on workplace violence, including guidance on reporting and the necessity for mandatory post incident reviews.

Root cause analysis can then inform action to address underlying structural reasons for violence suggested by incident investigations, such as interactions dominated by a limited setting, inconsistency in staffing, impoverished and physically unsuitable environments, low rates of engagement with children and young people, or poor job design. A training needs analysis can then inform the development, implementation, and evaluation of a training strategy.

The training strategy, however, must embrace much more than crisis management in considering underlying skills deficit in direct care and other staff. These may include the need to revisit what might already be expected to be in place, such as core professional values; positive beliefs about the capacity for recovery, growth, and change in children and young people; and collaborative approaches to care planning and the use of structured risk assessment or management plans.

In addition, advanced training in interventions such as psychotherapy, psychosocial interventions, and motivational interviewing should be considered. Staff must have the necessary skills to undertake the focused, structured, evidence-based interventions that can possibly avert violence before it occurs, and not just training in how to manage crisis more effectively (Goldstein, Glick, & Gibbs, 1998).

Assuming such skills exist simply belies the reality of many children's homes. Crisis management training should not be used to compensate for failure to deliver on good practice in areas such as general staff development, staff appraisal, and clinical supervision (Anglin, 2002).

The idea of a total organizational response must be taken further in many care settings. An active partnership among children and youth, care staff, clinical staff, the wider organization, and other agencies involved, such as criminal justice, is required.

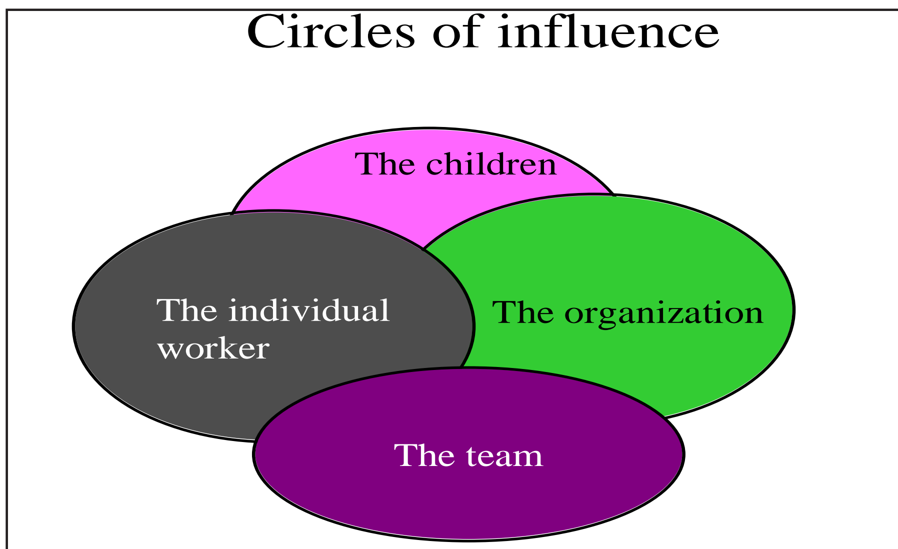

Figure 2

agement training, prosocial skills and values training, and contingency management may be required.

Action at the Staff Team Level
Explicit attention to workplace culture is vital. Organizations where staff feel devalued and disenfranchised are unlikely to provide a suitable therapeutic regime. If we deny staff the means to satisfy their existential needs—including the need to feel valued and effective, as well as the need for stimulation and excitement—we should not be surprised if the result is malignant aggression (Fromm, 1977). All too readily, an invidious combination may be produced where the frustration of legitimate desires by care staff in their professional lives produces hostility which, via displacement, expresses itself in regimes of care that consist largely of control and coercion (Bowie, 1998).

Service users' reactions to such regimes can create a vicious circle of punishment and yet greater control. Care settings where violence occurs must constantly refocus their professional roles, lest they find themselves only reflecting the patterns of blame and vengeance common in society (Fisher, 2003). Aggression in service users may invoke counter aggression in care staff. Staff must anticipate, acknowledge, and manage such reactions (Mullen, 2003). Fisher discusses the Stanton-Schwartz effect, whereby order "disintegrates when staffs do not resolve conflicts with each other." The compelling suggestion is "that consumers accurately mirror and enact staff tensions" (Fisher, 2003). Enabling staff to recognize and work through conflicts before they affect service users is, therefore, necessary.

Action at the Individual Worker Level
Training in skills such as risk assessment and proactive risk management can reduce violence by drawing staff attention to the reasons behind an individual's violent behavior, and prompt staff engagement before aggression is imminent (Needham et al., 2004). A focus on training for staff in direct contact with children and young people can, however, neglect the significant training needs of managers who may need help moving beyond prevalent cultures of victim blaming, and implement approaches, such as root cause analysis, to identify causal factors at all levels, including organizational culture. Training in crisis management does play a role but must be approached only with considerable caution and only once primary prevention has been addressed.

Action at the Child and Youth Level
This relates principally to individual care and program planning. Each child or young person must have an individual care plan and, where violence is an issue, the plan must identify underlying problems related to his or her violent habits and the circumstances in which violence can likely occur. An agreed upon crisis plan also identifies preferred coping strategies to use in advance. This is when structured interventions using psychosocial interventions, anger management training, prosocial skills and values training, and contingency management may be required.

Secondary Prevention. Depending on the context, secondary prevention may be planned or unplanned. In some situations, violence by children and youth may involve highly predictable patterns of response. Knowledge of such patterns, gathered via functional analysis, can allow staff to plan proactive positive interventions to prevent violence. Where violence may not be preventable, however, it can allow for planned reactive strategies to be devised and tested.

These can guide staff when the behavior of children and young people follows a pattern of escalation, so that imminent violence might be recognized early and averted. Such planning, where practical, should be done in conjunction with children and young people, allowing them to recognize and use their preferred coping strategies.

Tertiary Intervention. In this context, violence is either happening or has happened. Staff have been unable to prevent its occurrence and are now focused on reducing the risk of violence-causing physical or psychological harm. Strategies to manage immediate violence will vary, depending on risk assessment and organizational policy, but may include withdrawal by staff, the removal of other services users who may be a risk, and forms of physical intervention such as blocking or breakaway strategies that enable staff to remove themselves from the threat. Prolonged or more serious violence may necessitate physical intervention in the form of restraint—either physical or mechanical—or seclusion or medication. Clear protocols must be in place that detail the nature of the response expected by each member of the clinical team and each agency.

Once immediate crisis has passed, organizations must do several things:

- Review the incident. Put whatever lessons need to be learned organizationally into action to avert or improve the management of similar situations.
- Review the care of the individual

involved. Action is taken related to the individual's care plan to avert future crisis and enhance crisis management.

- Review the actions of staff involved so that any acts or omissions that may have contributed to the incident or detracted from its successful management are identified, recorded, and addressed. This does not necessarily mean management must conduct an investigation, unless serious misconduct is alleged or suspected and a supportive culture exists via peer review. In some instances, staff attitudes can be a problem, for whatever reason, and any investigation of alleged wrongdoing should therefore involve an external representative, such as an advocate.
- Promote positive outcomes for the children and young people involved. When appropriate, structured debriefs with the children or youth involved should be conducted to explore the antecedents, such as the relationships between feelings, behavior, and alternative coping strategies that might be used to deal with similar situations in the future. These can be practiced later in controlled simulations, such as role-playing, to help avoid future crises (Neizo & Lanza, 1984).
- Put in place flexible supports so that staff involved in incidents can access a range of supports at their discretion, including occupational health, telephone support, or peer debriefs.

Such interventions have the capacity to substantially reduce, if not eliminate, violence in many services. They reflect, however, an approach to pathology that is essentially ameliorative; for example, dysfunction is remedied at the level of the individual or the group (Prilleltensky & Nelson, 2002). If the root cause of most violence in our communities lies in profound economic and social inequalities, then such efforts on their own will always be inadequate. Gilligan (2000) argues that what is required is an agenda of "political and economic reform."

Only by embracing the need for such radical reform will we be capable of achieving what Prillenetsky and Nelson characterize as "transformative" intervention, capable, for example, of tackling the fundamental causes of violence. Intraorganizational efforts, therefore, must complement violence prevention efforts at a local and national level and recognize the need for political action.

Workplace violence in health and social care is a significant problem for many workers. Action within many organizations continues, however, to overemphasize training in the short-term management of violence, such as secondary prevention, and staff support after the incident, such as tertiary prevention. We need to actively engage the structural reasons that can give rise to such violence in the first place, both inside and outside our services.

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This article has been adapted from a paper originally presented in June 2005 to the International Conference on High Risk Interventions at Cornell University, New York.

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Implementing the Teaching Family Model in Day Treatment Programs

By Kambi Scott

Barium Springs Home for Children in North Carolina has a rich history of more than 100 years as a provider of children's services. In 1998, Barium began using the Teaching Family Model in its residential group homes and significantly reduced the use of restraint.

In 2003, Barium received a contract with the local managing entity (LME), which increased group home services from four homes to six and added five day-treatment programs to the service continuum. This article presents pre- and post-data demonstrating a significant decrease in restrictive interventions in the day treatment setting through implementation of the Teaching Family Model.

Day treatment, as referenced in this article, is a therapeutic mental health intervention to help school-age clients experiencing marked difficulty succeeding within public school settings. Typically, day treatment clients are verbally and often physically aggressive, are resistive to authority figures, and experience serious challenges interacting with peers. Most have experienced repeated failure in other settings and begin their day treatment experience with extreme caution and blatant defiance toward practitioners helping them.

Under these dynamics, transport, time out, and restraint are assumed to be accepted "evils" required to manage client behavior in any day treatment program. For example, though North Carolina regulatory bodies do not require the presence of a time-out room, all the day treatment programs Barium acquired through contracts included frequently used time-out rooms to manage client behavior. We encountered this again when we relocated one of the programs to our campus and community partners required us to create a time-out room before relocating.

Day treatment programs operated as they had before Barium's leadership from August 2003 to July 2004. This period is reflected in the pre-model implementation data in Figure 1. In July 2004, implementation of the Teaching Family Model began across day treatment programs at Barium under my direction; I had experience initiating this model.

The transition to model implementation consisted of participation in pre-service training by Barium Springs practitioners and the teachers and teachers' aids employed by the school system and working in the day treatment setting. Facilitating of skill development continued under the model consultants employed by Barium, offering program observations, reviews of motivation system data, crisis support, and behavior support planning to each program team.

Data Collection

Data was collected on frequency of restrictive interventions (use of transport, time out, and restraint) through a daily reporting system used across programs at Barium Springs. Each morning, one of the practitioners completes and electronically submits a report of incidents in the program from the day before. Incident occurrences are compiled by type and become a central piece of the agency's continuous quality improvement process.

Pre-model implementation data was collected from October 2003 to July 2004 across six day-treatment programs serving 63 clients, while post-model implementation data was collected from August 2004 to August 2005. During the 2004–2005 year, program services increased 55%, serving a total of 142 clients in six programs. The second-year of model implementation is partially complete for the first semester of the 2005–2006 school year and represents 73 clients in six programs.

Results

The first semester of implementation demonstrated a significant reduction in restrictive interventions overall (63% per client). The second semester of the first year of implementation showed dramatic reductions in all restrictive intervention areas (restraint, timeout, and transport) for a combined decrease of 68% per client. Clients are also served during the summer, exhibiting the lowest rate of restrictive intervention for the year (five restrictive interventions during the six-week period).

Examining the results of the first year of implementation, compared with pre-model incident rates, there was a 66% decrease in the use of restraint (from 2.5 per client to 0.84 per client), an 88% reduction in the use of timeout (from 2.3 per client to 0.28 per client), and an 87% reduction in the use of transport (from 1.94 per client to 0.25 per client). The total reduction in the use of restrictive interventions of any type in the first year of implementation was 54%. More significantly, the per-client decrease was 79%.

The second semester data for the second year of implementation continues to show the model's efficacy in reducing restrictive interventions. Across six programs serving 73 clients, the reduction in overall use of restrictive interventions, compared with the previous years data, is an additional 64% per client, or a 55% incident reduction. Comparing the current client incident rate with the pre-model data, the decrease in the use of restrictive interventions is a phenomenal

Figure 1

Barium Springs Home For Children					
Educational Program Restrictive Intervention Data Comparison					
	Pre-Model	1st Year, 1st Semester	1st Year, 2nd Semester	1st Year Model	2nd Year, 1st Semester
Number of Clients	63	59	64	142	73
Restraint Occurrence					
Number	156	98	21	119	32
Per Client	2.5	1.66	0.33	0.84	0.57
Per Client Reduction		34%	80%	66%	77%
Incident Reduction		37%	79%	24%	79%
Time Out Occurrence					
	Pre Model	1st Year, 1st Semester	1st Year, 2nd Semester	1st Year Model	2nd Year, 1st Semester
Number	142	26	14	40	13
Per Client	2.3	0.44	0.22	0.28	0.23
Per Client Reduction		81%	50%	88%	90%
Incident Reduction		82%	46%	69%	90%
Transport Occurrence					
	Pre Model	1st Year, 1st Semester	1st Year, 2nd Semester	1st Year Model	2nd Year
Number	122	22	13	35	21
Per Client	1.94	0.37	0.20	0.25	0.29
Per Client Reduction		81%	46%	87%	85%
Incident Reduction		82%	41%	71%	83%
All Restrictive Intervention Occurrences					
	Pre Model	1st Year, 1st Semester	1st Year, 2nd Semester	1st Year Model	2nd Year, 1st Semester
Number	420	146	48	194	66
Incidents Per Client	6.7	2.5	0.8	1.4	0.9
Per Client Reduction		63%	68%	79%	87%
Incident Reduction		65%	67%	54%	84%

87% (from 6.7 per client to 0.9 per client). This overall 87% is distributed across restrictive intervention types: a 77% reduction in restraint (from 2.5 per client to 0.57 per client), a 90% reduction in the use of timeout (from 2.3 to 0.23 per client), and an 80% reduction in the use of transport (from 1.94 to 0.38 per client). Figure 1 contains a visual representation of the data points described.

The Model

This significant data is due to implementing all aspects of the Teaching Family Model—a philosophy of care and treatment that prioritizes therapeutic relationships with practitioners as the primary conduit of effective treatment. Weaving advanced cognitive behavioral techniques, motivation systems, and person-centered interventions into daily life moments between clients and highly skilled practitioners, results in an unparalleled therapeutic environment second only to successful parenting.

The model is rooted in university research pioneered in the late 1960's at Kansas State University, Lawrence, Kansas. This research and the Achievement Place Project—the first group home to use model technology—played a significant role in laying the foundation for most of the cognitive and behavioral treatment modalities that have become a familiar body of research and practice today.

The model is founded on four systemic components which, when effectively integrated, create a structured organization that can be responsive to internal and external feedback, resulting in continuous quality improvement. The four components are:

Training. A practitioner's first year in the model is considered a training year. Beginning with an extensive pre-service training in all aspects of model implementation and regulatory requirements, the practitioner develops a highly professional skill repertoire that empowers him or her to recognize and respond to client symptoms immediately and therapeutically. Ongoing training allows practitioners and administrators to establish and maintain knowledge and skills relevant and responsive to the population served.

Consultation. A consultant or supervisor supports each team of practitioners. Consultation continues the training process through observation of practitioners' implementation of skills learned in pre-service. Through feedback, problem-solving discussions, and data analysis, the consultant develops the practitioners' ability to individualize the principles of the model for maximum effect with clients. The consultant provides on-call support, trouble-shooting for challenging client situations, coaching during times of crisis, and case management responsibilities for all clients.

Evaluation. The evaluation component provides accountability to serve clients with excellence within the philosophy of the model. Evaluation culminates in the sought after goal of certification as a practitioner by the Teaching Family Association.

Certification is attained through participation in a Teaching Family program evaluation, a comprehensive review of all program components. The review includes an onsite observation of practitioners' implementation of model principles with clients, a review of program data, observation of a team meeting, and a satisfaction survey of program consumers. Certification is a reward when each of the areas under review score a rating of three or higher on a four-point scale.

Individual practitioner certification is reached when the practitioner has participated in a certified program team and reached a rating of three or higher on a four-point scale in his or her annual performance evaluation. Recertification is conducted annually at the program and practitioner level. Evaluation also aims to ensure quality at an organizational level through examination of systemic patterns and trends, indicating success or the need for modification to the training, consultation, or administrative components of the model.

Facilitative Administration. The theoretical constructs of the model emphasize the essential role of the practitioner as the catalyst for change and healing in

IMPLEMENTATION, *from page 15*

clients' lives. In accordance with these principles, administration in the Teaching Family Model has a primary goal of supporting practitioners by providing the work environment, treatment, and fiscal resources necessary to equip them to deliver services in a family-sensitive environment using state-of-the-art treatment techniques and interventions.

Systems Integration. Each of the model components can also be found in non-model organizations in a departmentalized framework. Essential to model fidelity is the integration and continual interaction between the four system components—training, consultation, evaluation, and administration.

Although all of the components fulfill independent roles, they function interdependently, maintaining fluid responsiveness to one another. A systemic change in one area will automatically necessitate adjustments in all other components to ensure comprehensive service delivery. Demonstrated integration of all model components facilitates excellence in the organization and is required to meet criteria as a certified Teaching Family Model provider.

Significant reduction in Barium Springs' restrictive interventions through implementation of the Teaching Family Model technology has increased staff satisfaction, reduced staff turnover, and created a more therapeutic environment for the children we serve.

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Q: Should states include structural or institutional racism as a factor in how they mitigate racial disproportionality and disparity of outcomes?

POINT: By focusing on the correlation between poverty and maltreatment and individual and family levels of dysfunction, states can reduce racial disproportionality and disparity of outcomes.

by Kathleen Belanger and Deborah K. Green

One of our favorite quotes is from Niels Bohr, the atomic physicist (1885–1962): "The opposite of a small truth is a falsehood, but the opposite of a large truth may well be another truth."

A number of excellent studies have been conducted concerning racial disproportionality in child welfare, and as a result of these studies, we can be fairly sure of the following.

First, "There is a strong and well-established correlation between poverty, insecure income, welfare receipt, and cases of child maltreatment," (Roberts, 2002). Some studies, including all three waves of the National Incidence Study, have determined poverty is influential in predicting child maltreatment, independent of race.

Secondly, however, further analysis of the data show the interaction of several factors that combine to produce risk—families with low income, single parents, and large households outside of the labor force (Sedlack & Schultz, 2005).

Thirdly, race does matter within the child welfare system. Studies far too numerous to mention describe racial bias in reporting maltreatment to public child welfare, in screening, investigations, removal of children from the home, placement in foster care—in fact, in nearly all aspects of the child welfare system (Derezotes, Poertner, & Testa, 2005). African American children are less likely to be reunited with their families, stay in the system longer, and are disproportionately represented among the children waiting for adoption.

continued on page 20

COUNTERPOINT: States must include structural racism in their approach to addressing and mitigating racial disproportionality and disparity of outcomes in child welfare.[1] Segregation, exclusionary practices, and other inequities found throughout U.S. history have had an effect on public systems. It is imperative that structural racism be included with the same level of attention as poverty and maltreatment, and individual and family levels of dysfunction.

by Dennette Derezote

African American children are represented in out-of-home care at higher rates than their percentage of the population in every state. This information is true even though three national incidence studies show that there are no statistically significant differences in overall maltreatment rates between black and white families (Hill, 2006). When making comparisons for such factors as income level, unemployment, and whether the areas are urban or rural, African American communities actually have lower rates of child maltreatment than white communities (Ards, 1992; Korbin et al., 1998).

Additionally, Native American children—Indians, Hawaiians, and Alaskans—are all overrepresented in the jurisdictions in which they reside. Latino children are overrepresented in at least 10 states. But this information does not fully describe disproportionality and other disparities in the child welfare system.[2] Asian Americans and Pacific Islanders tend to be underrepresented in the child welfare system. And, if we look more closely at Latino representation throughout the country, we see that Latinos are overrepresented in some jurisdictions and underrepresented in others (Hill, 2006).

We also know that studies consistently show:

- As opposed to being referred to foster care, 40% of Hispanic/Latino children, 44% of African American children, and 72% of White children receive services in their own homes (Children's Bureau, 1993).
- When compared with white families, children of color have

continued on page 18

COUNTERPOINT, from page 17

less contact with child welfare workers, receive fewer services, and are substantially less likely to receive services in their homes (Roberts, 2002).

- African American foster parents reported fewer hours of contact between social workers and their children than was reported by other racial and ethnic groups (Berrick, Barth, & Needell, 1994).
- White foster care parents received more services than any other racial and ethnic groups.

These disproportionate outcomes, in addition to the above disparities in services and treatment, are examples of structural racism in today's society. To ignore this information when making decisions about children and families in public systems today is irresponsible.

No one can argue that poverty and maltreatment do not affect child welfare system involvement, or that families and individuals have challenges that create the need for out-of-home care. Indeed, several factors can affect child welfare system involvement of children and families of all races and cultures: federal and state policies, program administration, casework practice, community configurations, and individual and family factors.

Federal and state policies guide practice. As new policies are crafted, practices change based on new regulations and changes in funding. In addition, private agencies and regional state offices can have their own implementation guidelines that affect the way workers execute their jobs.

Communities are set up in very different ways and vary in terms of resources. How does community composition affect a family's experiences with the child welfare system? Families are diverse. Depending on their internal resources and strengths, families may need different types and levels of external resources.

What do we know about the things that strengthen families to work effectively? Each child is unique. Do children of different racial and ethnic backgrounds have the same experiences? If children of different racial and ethnic groups experience different types of abuse, alternative services might be needed to meet their needs. Are children's needs being addressed within the child welfare system? Are we developing and implementing child welfare services to best meet the needs of children and families of all races and cultures?

America is a blend of many types of people from all over the world to create one country. They have different histories in relationship to this country and they interact with its systems in different ways. At the same time, the children and families who represent the majority are white—75% of the population (Grieco & Cassidy, 2001).

Consequently, more often than not they are the sector of the population captured in studies designed to gather information for the development of policy. One example of this is a recently released study by the Urban Institute that examines a child care usage trend study that was used in the development of current child care policy (Capizzano, Adams, & Ost, 2006). While one could argue these policies are developed on national child care patterns, when these child care patterns are examined by race, as they are in this report, they hold for white children and families, but not among African American families. Also, the national patterns for Hispanic/Latino children and families tend to follow the identified national patterns more closely, but not identically.

Ultimately, these types of differences in policies, developed by studying national trends, can create an environment in which nonwhite families are not supported at the same levels that white families are, and, one could argue, put them at greater risk of child welfare system involvement than white families.

Unfortunately, many of our welfare policies are designed in this way—creating an environment of inherent structural racism. This means the policies best meet the needs of those who are in the majority, but less able to fit the needs of the remaining sector of the population. In the United States, this is 25% of the population, representing 69 million people (Greico & Cassidy, 2001), although unarguably less than the number of white people (211 million people), but still overwhelmingly large and obviously significant.

It is important for those developing programs and policies to recognize the unique needs, strengths, and histories of the individuals of various races and cultures within their jurisdictions. Their policy, program, and service choices will affect people of different races and cultures in unique and significant ways. If these important factors are overlooked, they may very possibly result in negative, unintended consequences.

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[1] *Structural racism* refers to "the many factors that work to produce and maintain racial inequities in America today. It identifies aspects of our history and culture that have allowed the privileges associated with 'whiteness' and the disadvantages associated with 'color' to endure and adapt within the political economy over time. It also points out the ways in which public policies, institutional practices, and cultural representations reproduce racially inequitable outcomes" (Aspen Institute, 2003).

[2] For purposes of this article, racial disproportionality within the child welfare system exists when children of one race or ethnic group make up a proportion of those in a child welfare event that is different from that same racial or ethnic group's proportion in the general population or another event (i.e. report, investigation, substantiation, entry into care, exit, etc.). Racial disparities within the child welfare system exist when children of one race or ethnic group make up a proportion of those in a child welfare event that is different from another racial or ethnic group's proportion in the same event (i.e. report, investigation, substantiation, foster care placement, exit, treatment, services, resources, etc.).

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

Question:
Should residential services only be used in emergency circumstances that are time limited (90 days or less)?

Point:
Nonresidential community-based providers can and have served at-risk children, youth, and their families adequately within their own community, eliminating the need for residential services.

Counterpoint:
Many agencies provide a comprehensive continuum of care model, including residential services for those children and youth that require a more restrictive setting. Placement should be based on a culturally competent, strength-based, comprehensive assessment of the child, youth, and family needs.

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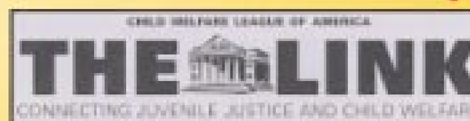

The Link
From CWLA's Juvenile Justice Division, this quarterly newsletter explores the link between involvement in the child welfare and juvenile justice systems. Available as a downloadable PDF file.* Receive e-mail alerts when the newest issue is available on the CWLA website! **Sign up at www.cwla.org/programs/juvenilejustice/jjdnewsletter.htm.**

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These studies are not contradictory, but complementary. Race matters in child welfare. Poverty matters in child welfare. And race affects poverty. How can we possibly address racial implications of maltreatment without addressing poverty when 33% of all African American children live in poverty, and when we know poverty can result in food insecurity, inadequate housing, and inadequate medical care, and contributes to behavioral, social, and emotional problems (Fass & Cauthen, 2006)? In addition, we know that eliminating poverty would reduce family stress and provide additional support and resources (Fontes, 2005). Addressing poverty expands the focus of disproportionality to a larger venue.

Recognizing the disparities in racial income and achievement in its communities, the Minneapolis-St. Paul region, for example, recently embarked on a far-reaching program to "mind the gap" and reduce disparities in race, class, and place to improve regional competitiveness (Sohmer, 2005).

Kalamazoo, Michigan, is offering free college tuition to all its residents in an attempt to achieve positive outcomes for the city. In a large, randomized field trial of school vouchers in three urban locations, African American children made significant educational gains in just two years, closing a third of the gap in educational achievement. What effect would these gains make on racism, poverty, and disproportionality in child welfare? If we only eradicate racism within our own public child welfare systems, would this eradicate disproportionality in child welfare? We think not.

Children of color, and particularly African Americans, are overrepresented in special education, the juvenile justice system, the adult prison population, and in child welfare. One-third live in poverty and experience all of the resulting consequences. We can't look at one truth alone, but at all of these truths and tackle all systems, trying every venue to close gaps and secure promising futures for all children. We need to work as culturally competent practitioners, not just with individuals and families, but also as community organizers and social planners, as researchers and politicians, as creative inventors, and as collaborators with all those who understand that child welfare affects the welfare of our nation. We cannot tackle racism without tackling poverty. We cannot tackle poverty without tackling racism. We have to tackle the bigger truths.

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