RESIDENTIAL GROUP CARE QUARTERLY

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Whatever Happened to Sound Clinical Reasoning?

by Elizabeth Kohlstaedt

For the past seven years or so, we in the mental health professions have been peppered with questions about whether our practices are evidenced-based. From regulatory bodies that oversee our work, insurance panels that fund treatment, graduate training programs, and professional associations—from all these sources there is pressure for us to demonstrate that the treatment we use has been shown to be effective for a particular disorder in a particular population.

A colleague of mine, who has been a psychologist for 20 years, was recently informed by an insurance company that she must prove she has been trained in a manualized protocol for treating posttraumatic stress disorder. The client she is treating has a posttraumatic stress disorder diagnosis but is also actively suicidal, depressed, and poor, with an abusive ex-husband and an extended family halfway across the country.

Although it makes sense to demonstrate our practices are effective in reducing the pain that brings clients to our doors, it makes little sense to ignore the fundamental principle that it is the relationship between client and therapist that makes any treatment effective. It seems we in the mental health field have succumbed to the belief that the scientific method always produces truth. We are scientist wannabes.

Science is but one particular discipline of thought. It attempts to control known variables to isolate the critical one that has an effect on the dynamic to be studied. It is only one discipline, however. Clinical reasoning, legal reasoning, philosophical reasoning, and moral and spiritual reasoning are other disciplines that are equally valid in coming to the truth.

Any of us who have testified in a legal proceeding are painfully aware that legal thought is distinct from clinical thought, and it leads to quite different conclusions. When we watched Andrea Yates being found guilty, the disparity between clinical and legal "truths" was evident. Within the mental health field and in the popular press, science is regarded as the only reasoning that is fundable or reliable in evaluating a treatment approach.

Evidence-based practices and outcome measurements are particularly cumbersome in working with children. How does one evaluate a child's ability to experience happiness or safety? How does one measure the intangible joy a child's smile can give an adult when that child feels successful about singing or reading—especially if that child could previously barely utter a word or would just as soon fling a desk at an adult as sing to her? What evidence can we collect to support a treatment approach that helps children put their feelings in words, even the overwhelming feelings of despair and insignificance, so they

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can share that burden with an adult who is just there to listen?

When we try to boil those intangibles into a neat little package, we end up with a checklist rated by an impartial adult. And it's just that impartiality that makes the measurement useless. It is the child's ability to engage in and sustain a rich relationship—one that includes pain and joy, hope and sorrow, connection, and anger—that holds our interest. The child may still urinate in the corner, or awaken with a nightmare, but he can also tell an adult about the meaning of those behaviors and get some relief from his experience of being damaged and unlovable. The child can share his story with another and, in the sharing, can co-create a meaning that is interpersonal and connecting. That is the outcome that we seek.

We can observe clinical changes in the child's ability to tolerate anxiety, venture into new activities, and feel soothed in a relationship, but documenting and quantifying this progression in a scientific way loses the clinical point. The child is experiencing some freedom and hope, and those of us who treat this child can see it and feel it.

Quantifiable behavior change can come about with medications that dull a child's senses. We hear the advertisements on TV and read the science in well-controlled drug studies and outcome studies. Scientific thought would have us believe we have a cure for the loneliness, isolation, emotional intensity and sadness that is part of the human condition—or at the very least, the cure is right around the corner. It's all just a matter of chemical imbalance—and for some children, this is true. Some children have disturbed brain chemistry that is primary in creating disturbed behavior.

For those children who come into our care through child protective services, it is their bizarre behaviors, wild emotional swings, emotions, inattention, and violence that tell the story of what has happened to them and how they anticipate the world to be.

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RESIDENTIAL GROUP CARE QUARTERLY

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Minorities as Majority

Disproportionality in Child Welfare and Juvenile Justice

First of two articles by Michelle Y. Green

In 1992, Congress amended the Juvenile Justice and Delinquency Prevention Act to make it a "core requirement" for states to demonstrate the efforts they're taking to reduce disproportionate minority confinement. Many lament that a decade of data gathering has produced considerable head-scratching, shoulder-shrugging, and finger-pointing, but little in the way of reversing this phenomenon. Statistics confirmed what child welfare professionals suspected all along: Far too many children of color pass from protection to punishment. With no such mandate to collect data in child welfare, disproportionality—its causes and cures—is just now coming to light.

In this two-part series reported from Children's Voice, *we examine this seemingly intractable problem. The first article tries to define the scope and nature of the problem, looks at emerging research, and explores a variety of perspectives from all sides of the table. The second article, which will appear in the next issue, will focus on several local jurisdictions that are meeting these challenges head-on with promising programs and practices.*

It reads like a bad math problem: If white youth and youth of color commit the same offenses and have the same history of delinquency, they should have the same likelihood of being detained. And if research concludes there are no differences in the incidence of child abuse and neglect according to racial group, minorities should not show up on child welfare rolls in greater numbers than in the general population.

Like students fathoming the travel distance of two trains going from point A to point B, so child welfare and juvenile justice professionals are wearing out their erasers trying to get a handle on the problem of disproportionality of minority youth within their respective systems.

That the problem exists is not disputed. But what needs figuring out is who, what, when, where, and why. Who are the children most affected? What are the social, cultural, political, policy, and programmatic reasons that this imbalance exists, and what can be done to intervene? When and where in the mix of services intended to support and protect children and society does disproportionality begin? Why are so many people so reluctant to deal with this complex issue?

The African American experience in this country, and other risk factors for abuse and neglect, are so intertwined, it's almost impossible to disentangle it.

Coming to Terms

A reasonable place to start is to define the term. That's exactly what the Casey Family Programs attempted to do, with input from the Children and Family Research Center (CFRC) at the University of Illinois at Urbana-Champaign, in its overview to *Addressing Disproportionality in the Child Welfare System: Defining the Issue,* released March 2002:

> Overrepresentation—particularly in reference to African American children—has traditionally been used to define the high numbers of children of color in the child welfare system that are larger than their proportion in the general population. However, with more frequency the term disproportionality is being used to identify a broader concept of this problem… By contrast, disproportionality refers to a situation in which a particular racial/ethnic group of children are represented …at a higher percentage than other racial/ethnic groups. For many people, both terms hold the same meaning and are used inter-changeably, but in fact they are not equivalent…

Former CFRC Director John Poertner, who has convened two *Race Matters* research forums, admits, "People who discuss this issue from a research point of view have an incredibly difficult time understanding it. The African American experience in this country, and other risk factors for abuse and neglect, are so intertwined, it's almost impossible to disentangle it."

Jorge Velázquez, former Director of Cultural Competence for CWLA, defines the problem in terms of who is and who is not being served. "We need to pay attention to rural, migrant, and Native American families and kids in the Midwest who disproportionately are not getting what they need. You can't express that in terms of overrepresentation, because these populations are a small part of the overall demographic picture. Or what do you do with places like Washington, DC, where most of the population is African American and so are the kids in care? That's a whole other question."

Nonetheless, there is consensus that multiple, complicated factors contribute to disproportionality in both systems. Welfare policies, poverty status, income level, lack of resources, community of residence, and single parenthood all have an impact on a family's involvement with the child welfare system. And many of these factors that put children at risk for maltreatment and subsequent involvement in delinquency are present, to a greater degree, in communities of color.

National longitudinal research, such as Building Blocks for Youth or the Annie E. Casey Foundation's Juvenile Detention Alternatives initiative launched in 1992, show that the racial disparities found in juvenile training schools and state prisons are the end products of actions that occur much earlier in the juvenile justice system, and that the effects of race accumulate as youth continue through the system.

"Data clearly reflect that the same factors that contribute to advancing children deeper in the child welfare

Disproportion by the Numbers

More than a decade of research and data collection has documented the scale at which youth of color are unequally treated at all points in the justice system. Compelling statistics about population, poverty, race and ethnicity, and other factors, as reported by the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP) and other sources, bring this picture into focus:

- In 1999, the U.S. juvenile population was 79% white, 15% black, 16% Hispanic, 4% Asian, and 1% Native American. This represents the 70.2 million Americans —more than one in four—who are under the age of 18.
- The population of juvenile minorities is expected to show significant growth between 1995 and 2015. Compared with a 3% increase for white juveniles, the number of black juveniles is expected to rise 19%, Hispanic juveniles by 59%, Native American juveniles by 17%, and Asian/Pacific Islander juveniles by 74%.
- In 1997, African American youth comprised 26% of youth arrested, 31% of referrals to juvenile court, 44% of youth detained, 46% of those waived to criminal court, 40% of youth sent to residential placement, and 58% of youth admitted to state prison. White youth were reported as committing higher levels of weapons possession crimes, yet African American youth were arrested at 2.5 times the rate of whites for weapons offenses (*And Justice for Some,* Building Blocks for Youth, 2000).
- On a given census day, October 29, 1997, nearly half of juvenile residential facilities had 50% or more minorities in their offender population. Minority youth accounted for between 75% and 100% of the offender population in 28% of public facilities and 21% of private facilities.
- Between 1983 and 1991, the percentage of Latino youth in public detention centers increased 84%, compared with an 8% increase for white youth. Latino youth are incarcerated at rates 2 to 3 times higher than the rates of white youth in nine states, 3 to 6 times the rates of white youth in eight states, and 7 to 17 times the rates of white youth in four states (Human Rights Watch, 2002).
- In 1997, three out of four youth admitted to state prisons were minorities; more than a third were nonviolent offenders. For youth charged with violent offenses, the average length of incarceration was 193 days for white youth, 254 days for African Americans, and 305 for Latinos.
- The average length of incarceration in state public facilities was longer for Latino youth than for any other racial/ethnic group in every offense category. Those charged with violent crimes spent an average of 143 days longer incarcerated than did white youth charged with the same offense; an average of 45 more days for property offenses; more than twice the time for drug offenses; and 147 to 220 days more than white youth for public disorder offenses (*¿Dónde Está la Justicia? A Call to Action on Behalf of Latino and Latino Youth in the Juvenile Justice System,* Building Blocks for Youth, 2002).
- In 2000, 11.6 million juveniles (16% of all youth under 18) were living below the poverty level. The proportion of white juveniles in poverty (13%–17%) has remained relatively stable since 1982, whereas poverty rates among black youth (33.1%) and Hispanic youth (30.3%) in 2000 were more than twice that of white and Asian juveniles.
- More than half of African American children lived in single-parent households in 2000. Most white (83%) and Hispanic children (75%) lived in two-parent homes.
- High school completion rates were consistently lower among young Hispanic adults than among both whites and blacks between 1972 and 2000, fluctuating between a low of 56% and a high of 67%.

*Source (unless otherwise noted): *OJJDP Statistical Briefing Book* (2002). Available online at www.ojjdp.ncjrs.org/ojstatbb/html/qa096.html. Washington, DC: Office of Juvenile Justice and Delinquency Prevention.

system exist in the juvenile justice system," explains John Tuell, Director of CWLA's Child Welfare Juvenile Justice Systems Integration Initiative. Although most examinations of the problem from the juvenile justice perspective look at arrest and beyond, Tuell says we need to look at causal factors, from arrest backwards. "At the heart, many would agree that the problem of disproportionality is attributable to social and economic issues."

Poverty establishes risk factors for increased involvement in delinquencies, Tuell says, whether it exists in urban, rural, or suburban settings. Children in poverty are more likely to come from single-parent working families, where there is a decreased likelihood of supervision at critical times during the child's day. During these times, they are more likely to experience negative peer culture, which in turn makes it easier to become engaged in more negative activities. Combine these factors with increased crime rates in a particular neighborhood, police strategies that result in greater concentration of enforcement, and fewer alternatives to arrest and processing, and the picture becomes even clearer.

James Bell, director of the Youth Law Center's W. Haywood Burns Institute in San Francisco, has analyzed existing policies and procedures to address the causes of disparate treatment of minority youth. He offers a scenario of how cultural and racial bias in the decision-making process—at every point in the system—disadvantage minority youth:

> Let's say you go joyriding and are busted for attempted car theft. If you're arrested and taken to detention, that's a decision. If you're white and live in the suburbs, you may be taken home; if you're not white and live in the city, you're probably going to be taken to a detention center. That's a decision.
>
> If you score 120 points or above on a risk assessment, you stay detained. If you're a first-time offender, you should be released, but when you call home, no one answers. Perhaps your mom, a single parent, has to work two jobs, and grandma doesn't have a car. The system doesn't feel comfortable releasing you because there isn't supervision. It's so much easier to send you to detention, but that leads to further incarceration and more decisions that you're too dangerous to release. Are you in school? That may work against you if you live in a neighborhood where you don't feel safe dealing with schools and gangs. Do you have a job? There may not be a lot of jobs where you live.
>
> Suppose you're cited for hanging around a high-crime area that just happens to be your neighborhood. So your court date comes around, and you don't show up. Is it genetically imbedded that you don't show up, or is it because public transportation on your side of town doesn't get there in time for morning court? We have to look behind the numbers, which appear to be race neutral, or you'll continue to get the same results.

The question of bias in the decision-making process is mirrored in the child welfare system in several studies…

Bias is compounded as minority youth move through the system. Risk-assessment instruments used at intake that use broad criteria like "good family structure" might be unintentionally biased toward intact, nuclear families, which might work against minorities. Minority youth are largely represented by overburdened public defenders and, as a result, generally experience more restrictive outcomes than youth represented by retained counsel. An absence of minority-run, community-based organizations that service delinquent youth leaves detention as the option of choice. Public fears over gangs, immigration, and high-profile youth crimes also affect commitment decisions.

"It's not always about racist workers. It's about racism by neglect—a lack of cultural competence in systems."

The question of bias in the decision-making process is mirrored in the child welfare system in several studies that identify race as a predictor in the decision to place children in foster care. Lacking the federal incentives that exist on the juvenile justice side, child welfare is behind the curve when it comes to substantial research and sustained conversation on the matter. But consensus does exist on one point—as a prerequisite of change, the two systems have to collaborate and integrate services and resources to meet the needs of children, regardless of how, why, or when they enter the system.

The Faces Behind the Numbers

Who are the children behind the numbers? If you poll states for specific demographics broken down by race or ethnicity, Velázquez says, you'll find we don't know. "Some states do better than others in collecting information about people they serve. One state with a large population of Spanish-speaking individuals, for example, still classifies Hispanics as 'other.'"

The perception is that disproportionality is primarily a problem for African Americans, he says. "In some parts of the country, that's true; in others, it's not. We need consistent definitions to describe the faces we're talking about."

Flawed, inconsistent reporting, underreporting, and the failure to collect data that reflect changing demographics—these factors contribute greatly to the disparate treatment of Latino youth

in the U.S. justice system, according to Building Blocks for Youth's report, *¿Dónde Está la Justicia? A Call to Action on Behalf of Latino and Latina Youth in the Juvenile Justice System*.

The practice of reporting large numbers of Latino youth in the "white" category, the report points out, "inflates white incarceration rates and masks the already substantial rates of disproportionality between white youth and youth of color." The more reporting systems combine flawed data, the greater the chance that evidence of racial disparity is lost and hidden.

By contrast, the juvenile justice side has collected so much data, Bell contends, it's bogged down in the "paralysis of analysis." Statistics from the U.S. Office of Juvenile Justice and Delinquency Prevention (OJJDP) reveal one aspect of the problem, Tuell says, yet "many states don't even have enough categories to record sufficient data."

Child Welfare: What We Know

Research on disproportionate representation in the child welfare system is not as exhaustive as that for juvenile justice, but what evidence exists points to striking similarities of disproportionality along a continuum of services.

- Three National Incidence Studies of Child Abuse and Neglect, conducted by the U.S. Department of Health and Human Services (HHS) from 1980 to 1996, found no differences in the incidence of child abuse and neglect according to racial group—yet African American children are clearly overrepresented in the child welfare system. Though the data are controversial, many people use them as a baseline to measure the problem from a child welfare perspective.
- When maltreatment is recognized by mental health or social services professionals, families of African American children are more likely to be investigated for emotional maltreatment and neglect, fatal or serious injury, and perpetrator involvement with alcohol or drugs. However, when disadvantaging characteristics (low income, large family size, single-parent homes) are factored in, African American children are maltreated at lower rates than white children.
- African American children, who comprised 15% of the U.S. child population in 1999, constituted 45% of the children in substitute care. Converse-ly, white children, who comprised 60% of the child population, accounted for 36% of children in out-of-home care (U.S. Census Bureau, 2000).
- Of those requiring substitute care, most African American children (56%) are placed in foster care, while most white children (72%) receive in-home services (Annie E. Casey Foundation, 1999; HHS, 1999). African American children also remain in foster care for longer periods of time (U.S. Children's Bureau, 1997).
- Five major studies in four states between 1990 and 1999 revealed that white children are four times more likely than African American children to be reunified with their families, and they are reunified more quickly. In San Diego, reunification rates were lower among Hispanic children than for white children.
- Disproportionate numbers of children who are reunified ultimately return to foster care, with "race of the child" identified as one of five strong variables in decisionmaking.

*Source (unless otherwise noted): *Race Matters: The Overrepresentation of African Americans in the Child Welfare System,* a compilation of draft papers presented at the *Race Matters* Forum, January 2001, cosponsored by the Children and Family Research Center and Westat. For more information on this forthcoming publication, contact: Children and Family Research Center, School of Social Work, University of Illinois, Urbana–Champaign, 1203 W. Oregon Street, Urbana, IL 61801, 800/638-3877, 217/333-5837, Fax 217/ 333-7629, e-mail cfrc@uiuc.edu, or visit http://cfrcwww.social.uiuc.edu.

Although there are no national studies on the subject, several smaller studies have found that minority children are at a disadvantage in the range and quality of services provided, the type of agency to which they are referred, the efficiency with which their cases are handled, the support their families receive, and their eventual outcomes. Clearly more needs to be done on the child welfare side to put this problem into clearer view.

"When you back down the system, you'll find the same kids that are moving through the juvenile justice system were all right there in child welfare," says CWLA Vice President of Corporate Communications and Development Linda Spears.

Turning the Tide

What are some of the barriers the child welfare and juvenile justice systems face, as they take a hard look at what can be done to turn the tide of disproportionality and foster a climate of collaboration?

Reluctance to talk. "People are reluctant to talk about this issue because they don't know what to do about it," says CFRC's Poertner. "The feeling is, 'It's too complicated. I don't know if it's our fault, and I don't know what to do about it.'"

Bell says, "Unless you solve institutional and individual poverty and racism, some believe you can't do anything about it. That's simply not true."

Lack of federal leadership. "A stronger federal mandate and direction on this issue is necessary," Tuell says. "OJJDP reporting focuses on confinement, but there's nothing to measure the impact of those strategies and interventions —no number or percentage of reduction, no specific outcome measurement that allows us to say we're making progress."

Inconsistent or insufficient data collection. Many systems lack sufficient focus, determination, and resources to even begin to identify, let alone eliminate, the multiple factors that

end in racially unequal treatment. Critical requirements are consistent categories across systems and detailed data to help analyze how decisions are made.

Lack of cultural competency. The lack of adequate bilingual services through both systems is an obvious barrier, but so are risk assessment instruments that are racially or culturally biased and a general failure of staff to understand cultural differences. Misunderstandings can lead to inappropriate and harsher treatment. For example, avoiding direct eye contact is considered respectful in many Latin nations, but in European culture, it may be seen as a sign of disrespect or deceptiveness by authority figures. "It's not always about racist workers," Spears says. "It's about racism by neglect—a lack of cultural competence in systems."

Insufficient diversion alternatives. Where parental supervision is not possible, youth detention alternatives, such as shelter care, foster homes, home detention, and day reporting centers, would reduce more punitive confinement.

Overwhelmed, underfunded systems. The systems themselves face many problems, ranging from a lack of authoritative leadership charged with setting policy and controlling budgets, to inadequate resources for research, training, or developing new community-based programs.

Looking Forward

Every year, more than 100 prominent juvenile justice and child welfare leaders met in a CWLA-sponsored National Juvenile Justice and Child Welfare Summit. Among the topics discussed are coordination and integration to address disproportionality at all points in the two systems. As they continue to communicate at nonthreatening sessions like these, and share research in forums such as *Race Matters*, the conversations will move from abstract principles to concrete strategies. ❑

The Elephant in the Living Room

"The process seems geared to putting African American males into the system one way or the other, whether it's an arrest, which throws you headfirst into the criminal justice system, or something as trivial as an incident stop, which gives police the opportunity to collect personal data on you for no more than walking the streets in your own community.

"I tell my sons that, as African American males, they have to be prepared for confrontations with the police. I tell them they have to dress not to fit a profile; to stay out of large groups; if they're driving in a car, not to have a crowded, packed vehicle; if stopped by the police, to pull over immediately, to respond 'Yes sir' and 'No sir,' to follow instructions implicitly; and, as much as possible, to quietly, mentally document names, badge numbers, car numbers, times, dates, and places.

"Living in suburban Maryland, my oldest son grew up in a racially mixed environment, and his best friend was white. A youthful indiscretion, and the two of them ventured into the District to purchase a nickel bag of marijuana. The car they were driving in was observed by nonuniformed police officers, and they were stopped after they made their purchase. Both were pulled out of the car. Neither had marijuana on him, but some was found in the car, which belonged to the other boy's parents. The two were separated. [The white youth] was scolded for being in the neighborhood and placing his parents' vehicle in jeopardy of seizure. He was sent home. My son was arrested because the marijuana was found 'in proximity' of where he sat in the automobile.

"According to the law, you have to be in possession to be arrested, and drugs are presumed to be the possession of the person driving the vehicle. I'm not complaining about my son being arrested—both admitted to the purchase—but [the other youth] was given 'a walk' because of the color of his skin, and my son was given a record. And it happens all the time.

"Racial profiling is a necessary evil of police work, and racism is a part of the system. Nobody likes to deal with the elephant in the living room, but if you don't, everything else is tainted."

William Russell is a former officer of the Washington, DC, Metropolitan Police Department. An African American and father of four sons, he has seen the system from both sides of the squad car.

The second article in this series will explore several of these promising strategies in communities such as Santa Cruz, California; Multnomah County, Oregon; and Chapel Hill, North Carolina.

Michelle Y. Green is a freelance writer in the Washington, DC, area, and author of A Strong Right Arm: The Story of Mamie "Peanut" Johnson ***(Dial Books for Young Readers). This article originally appeared in the November/December 2002 issue of*** Children's Voice.

Point/Counterpoint

Q: *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 communities, eliminating the need for residential services.

by James L. Murphy

Nonresidential community-based providers are an integral part of an array of services to young people and their families. These providers can prevent the removal of a young person from his or her home and family, and can minimize the disruption and destruction of the family unit. Services are provided in least restrictive settings, in homes, and help young people and their families avoid the pain of loss and separation that can occur when a child is removed from home and placed in a residential facility with other youth. In fact, residential settings should be avoided whenever appropriate nonresidential services are available to meet the specific needs of a child and their family.

The American Association of Children's Residential Centers (AACRC) indicated in its position paper, *Redefining the Role of Residential Treatment,* "There is a substantial and growing body of research indicating that system of care models have demonstrated effectiveness in providing treatment and support for children with serious mental and behavioral disorders and their families, utilizing in-home, wraparound, and community services."

I applaud the field for these advances and support efforts to effectively provide nonresidential community-based services that minimize the disruption to families. At the same time, I continue to advocate for the simple and

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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.

by Christopher Bellonci

Who can argue with keeping kids with their families, attending their local community schools, and maintaining their natural sources of support within their communities, if they are able? But do we really want to remove the option of a 24-hour treatment milieu for those children and youth in greatest need? Do we truly believe all children can be served in the community? And if we believe in family-driven care, shouldn't families have the option of choosing 24-hour treatment settings for their children?

I am a child psychiatrist who has worked in a variety of settings including inpatient, outpatient, private practice, schools, community mental health clinics, and, most recently, at Walker Home and School, a residential treatment center. Having sampled these various models of service delivery, I am extremely impressed by the power of a 24-hour treatment milieu to treat society's most troubled children and youth. At Walker, I have been able to provide a level of thoughtful, scientifically supported psychiatric care that was not an option either in inpatient or outpatient settings.

Inpatient settings often do not allow for the time necessary to address the complex behavioral and biological issues with which my patients present. The goal there is to put out the fire that led to the admission. Often, children will have cycled through multiple hospitals over the course of several

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admissions, and the only real change is the increasing number of medications they are prescribed. And outpatient settings are often inadequate to ensure the safety, structure, and stability needed by many of society's most complex and challenging children and youth.

Who are the children for whom a 24-hour treatment modality makes sense? I will provide some examples from my own clinical practice. I will use each example to highlight one theme or class of children who might benefit most from residential treatment.

The first example is of a child with schizophrenia. This child has a supportive, loving, knowledgeable family who advocates strongly for their son's needs.

Despite numerous medications and many past med trials, he remains acutely fragile, and when he is out of the 24-hour treatment setting for longer than a day he starts to hallucinate. His odd and sometimes dangerous behavior ends up scaring his sister, who has needed treatment to manage this stress. His parents have been offered in-home supports but find them intrusive.

The family structures their time with their son in order to support his visits home, but even with this structure, he deteriorates quickly while home. They have made the decision that, at least for now, Walker is the least restrictive setting for him.

The next example is one of a child who was in an inpatient setting for six months. While there, he was placed on four different psychiatric medications within a month, in addition to the two prior medications he was taking. Despite the additional medications, his behavior did not improve.

Residential treatment is powerful medicine. And like most powerful medicines, it comes with both risks and benefits.

When he came to Walker, we convened our multidisciplinary team and found he had a previously undiagnosed nonverbal learning disorder. That information, as well as knowledge of his past trauma, explained many of the behaviors we were seeing and that had been reported from the hospital. When we developed a treatment plan reflecting this new understanding, he improved; over the course of several months, he was able to come off almost all his medications, and he is no longer acting out aggressively.

This is an example of the benefits of high-level, multidisciplinary assessment and treatment, delivered in a 24-hour milieu that can observe, manage, and teach new behaviors. The residential facility was able to manage the potential of his behavioral regression in the service of reassessing his need for medications —a process that would have been too unsafe in an outpatient setting.

The final example involves risk. Shaliekwa came to Walker shortly after the death of her brother as a result of a rare, hereditary cardiac condition. The only treatment for the condition was a heart transplant, but children cannot receive heart transplants unless they have a home and family to care for them. The Department of Social Services was unable to identify a home willing to meet his complex medical and psychiatric needs, so he was not eligible for a transplant, and he succumbed to his illness.

A month after her brother's death, Shaliekwa was diagnosed with the same condition. Without Walker's willingness to take care of Shaliekwa after her surgery, she would not have been considered for a transplant. Shaliekwa received a new heart this past June and is back at Walker working on the behavioral and emotional issues she had before surgery. Although this is a dramatic example, residential programs can help support extremely complicated, emotionally and behaviorally disordered children, until they are ready to transition to community-based care.

Residential treatment is powerful medicine. And like most powerful medicines, it comes with both risks and benefits. We must answer the practical question of who should receive this powerful medicine, what the residential program should look like, how it will interface with community supports and services, and what is the right dose of this medicine (in other words, what length of stay might be necessary). But we must not take the option of this powerful treatment setting out of the hands of families and children in need. ❑

Often, children will have cycled through multiple hospitals over the course of several admissions, and the only real change is the increasing number of medications they are prescribed. And outpatient settings are often inadequate to ensure the safety, structure, and stability needed by many of society's most complex and challenging children and youth.

Christopher Bellonci MD is Medical Director at the Walker Home and School, Needham, Massachusetts.

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widely recognized principle that treatment plans and the services provided must be individualized for the unique needs of each person and family receiving services. When a needs assessment is completed, it is the responsibility of the provider to ensure services are customized. This includes the determination of location and environment where services will be provided. To fulfill this task responsibly and ethically, one must consider all available options, including the consideration that a residential setting or service may be most appropriate.

> *Mandating that youth "fail into" a residential setting… often forces a child or family to deteriorate before getting the services they need…*

Failing to recognize residential care as a viable and sometimes most appropriate level of care creates a tremendous gap in the array of services needed to provide wraparound services. The community needed to raise a child is missing useful resources if residential care is not carefully considered as an option.

All too often, residential care is used as a last resort to the detriment of a child. Mandating that youth "fail into" a residential setting, after exhausting other less restrictive levels of care, often forces a child or family to deteriorate before getting the services they need and from which they can benefit, even when those needs are evident from the beginning. For some, the process must in-clude multiple failures before they are finally afforded the opportunity to succeed—an opportunity that could have been provided much earlier. Our systems of care need to be based on the health and safety of those receiving services, and these must provide for their well-being and improvement. We cannot allow a system to be in place that causes pain rather than reducing it, or increases dependence on services rather than reducing the need and length of services.

Where did we stray from the notion of "least restrictive and most appropriate" to "a linear notion of 'continuum of care' as a case management blueprint…" as mentioned in CWLA's position statement on residential services? We are failing to provide the best possible services at the most appropriate and opportune time, when we force the exhibition of negative behaviors in order to access the care and treatment needed. How does this best serve youth and families? It doesn't.

AACRC reports that "not all children consistently respond well in open community settings and some need stays in residential care for periods of time." In addition, "states and locations that have eliminated residential services have experienced increases in hospitalization and/or the necessity to reestablish residential capacity."

As noted in CWLA's position paper, "The primary purpose of residential care is to address the unique needs of children and youth who require more intensive services than a family setting can provide. Either on site or through links with community programs, residential facilities provide educational, medical, psychiatric, and clinical/mental health services, as well as case management and recreation. Within residential care settings, children and their families are offered a variety of services, such as therapy, counseling, education, recreation, health, nutrition, daily living skills, pre-independent living skills, reunification services, aftercare, and advocacy."

Providing these residential care services, the manner and intensity at which they are provided, and the unique wraparound nature of them make this level of care an important part of the overall system of care that should be available as a viable option, based on the unique comprehensive evaluation of a child and/or family's needs.

The growing recognition of the importance of residential services is evidenced by recent articles and position papers, such as the CWLA's position paper on residential services, AACRC's position papers *(Redefining the Role of Residential Treatment* and *Redefining Residential: Becoming Family-Driven),* and SAMHSA's *Building Bridges Summit Joint Resolution Statement,* developed by residential- and community-based service providers, and family and youth members.

Numerous residential care providers are implementing and incorporating community-based and wraparound services in residential settings before discharge to maximize the benefit of treatment post-discharge. Rather than creating hostile environments where providers are literally competing over clients, we need to provide a more collaborative, holistic approach to treatment, and we need to work together with the best interests of the youth and families in mind. ❑

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Information on AACRC's position paper can be found at www.aacrc-dc.org. CWLA's information can be located at www.cwla.org.

In the next

Residential Group Care

Quarterly *Point/Counterpoint...*

SERVING SEXUAL MINORITY YOUTH IN RESIDENTIAL SETTINGS

CLINICAL REASONING, from page 2

For those children, medications may silence the symptoms temporarily, and cognitive, rational approaches that encourage self-control may make their behavior more manageable while they are in treatment. In the long run, however, these approaches may harden a child's sense that he or she is different and damaged and just needs to be quiet; and that the really horrific parts of this child's story are too much to be tolerated. Children stop telling adults about what is going on inside them because no one listens; we tell them how to talk without listening to what they need to say.

The way a small child expresses her sexual abuse, for instance, can be disturbing if she tells us by inserting objects, masturbating openly, or seductively lap-dancing with an adult male. Likewise, the child who threatens to kill his adoptive parents in the middle of the night may trigger so much fear in adults that we forget to ask about the anxiety and rage the child is experiencing. We fail to explore how the objectionable behavior is simply expressing this child's current and past experiences.

That which is relationship-caused needs to be relationally treated, but this is a clinical thought, not a scientific one. We can build flowcharts, isolate hypothetical variables, and make testable predictions—in doing so, do we engage in a scientific argument, when what we need is a clinical one?

We need to be able to help those who form healing relationships with children to *work clinically* with them. We need to train others to tolerate the depths of a child's pain and to listen—to *be there* with the child without rescuing or promising false hope that only makes the adults feel better. We need to understand the meaning and history beneath bizarre behavior; to feel it, tolerate it, and then describe it back to the child to check for accuracy.

As we attempt to resonate with the child's experience, we must separate it from our own pain, so we are not unconsciously trying to soothe our own hurts. And we have to teach the direct care staff—those who spend most of the time with the children in care—to use themselves as instruments of healing as well. This requires them to be curious about their own experiences, share those experiences with their colleagues and feel the relief in a shared narrative. Finally, we must help those staff who cannot tolerate this work—those who are critical, harsh, judgmental, and punitive when encountering pain in children—to find other lines of work that might be less taxing and less potentially damaging.

It is hard, emotionally demanding work to bring rich relationships into the lives of children who have only experienced painful ones. It is not work that is readily quantifiable, or work that holds the promise of a cure for the pain of life. The most useful discipline is a clinical understanding, rather than cold scientific thought that seeks replication and verification.

Now if we can only help funders, regulators, and wannabe scientists understand that. ❑

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