RESIDENTIAL GROUP CARE QUARTERLY

VOLUME 5, NUMBER 4 CHILD WELFARE LEAGUE OF AMERICA SPRING 2005

Instrument for Assessing Behavioral Change

By David Colton, PhD

Currently, numerous assessment instruments in the marketplace are designed specifically for the child and adolescent behavioral health care population. These measures, however, may not provide the information treatment teams need, nor are they designed to produce data at a frequency teams may require for treatment decisionmaking.

Most instruments are designed for intake assessment. Some are also adapted for post-treatment assessment to function as an outcome measure (Lyons et al., 1997). To accomplish this, many of the instruments contain a large number of items that may be of limited relevance to a residential setting. For example, items about the home/caregiver environment provide useful information for initial assessment or discharge planning, but have limited use as a measure of behaviors during residential treatment.

To accomplish the goals of a generic assessment, frequency of behavior is rarely a unit of measurement. Frequency data, however, may produce useful information for treatment teams interested in observing an increase in positive behaviors or a decrease in unproductive behaviors.

This suggests it is possible to construct an instrument specifically addressing aspects of symptomatology or functioning that interests treatment staff. For example, it may be possible to construct an instrument composed of subscales that tap into a diagnostic domain, such as depression, anxiety, or self-injurious behaviors, and where varied item types can indeed measure both severity and frequency. Minimally, such an instrument can provide multiple measures of a single construct, thereby giving treatment staff a more global picture of the client's level of functioning related to their symptomatology.

Facing this challenge, the Commonwealth Center for Children and Adolescents in Staunton, Virginia examined existing instruments and determined it is more productive to create a measure providing information sought by its treatment teams. The following goals guided the project (Vibbert and Youngs, 1996):

- The assessments should be appropriate to the application or question being answered.
- Assessment tools and systems should have demonstrated validity and reliability and must be sensitive to clinically important change over time.
- Assessment systems should have minimal respondent burden (for example, they are efficient to complete and score) and can be adapted to different health care systems.
- Assessment instruments should include generic and condition-specific information that can predict expected consumer outcomes.
- Assessments should include areas of personal functioning affected by the condition or conditions of interest.
- Outcomes should be assessed at clinically meaningful points in time given the disorder's course.

In constructing the instrument, determining its specific purpose should be one of the first considerations. For

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Residential Group Care Quarterly

Volume 5, Number 2

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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example, should the instrument be generic, covering related mental health domains such as the Child & Adolexcent Functional Assessment Scale (Hodges, 1997), or should it be condition-specific, addressing one construct thoroughly, such as the Beck Depression Inventory (Beck, 1996)?

Similarly, it is important to identify, in advance, important population characteristics that will be assessed, such as age, disability, or diagnosis, and considerations about setting. For example, this proposal specifically addressed the need for an assessment instrument for a juvenile population (most likely ages 7–18) in an inpatient/residential setting.

Another consideration is whether the instrument should measure the presence or absence of symptomatology or a level of functioning. Similar to assessment is whether items will measure severity or frequency of occurrence. Answering these questions helps in conceptualizing items and response sets.

Yet another consideration is whether an independent rater completes the instrument or if the instrument is completed through self-reporting. Self-report instruments may be more efficient to administer because they reduce staff time to complete. Respondents' motivation and functioning level may influence the usability and accuracy of responses. Consequently, it may be necessary to design several forms of an instrument to address respondents' ages and reading abilities, the interference of symptomatology, and other issues.

Conversely, instruments completed by independent observers/raters may produce more reliable information, but only after extensive training to ensure a high level of reliability. These factors must be taken into consideration during the design and development process (for example, see Ciario et al., 1986, Kane, 1997, and Silva, 1993).

Responding to this challenge, the writer developed the Child and Adolescent Behavioral Rating Scales (CABRS) to provide a consistent, stable approach for measuring variation in observed behaviors. This behavioral rating scale can be used to measure and identify changes, including trends and patterns in specified behaviors.

The instrument has 64 defined behaviors. Space is available to add behaviors not reflected in these scales. The items are grouped thematically: anxiety, depression, communication problems, psychomotor activity, attention problems/hyperactivity,

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conduct problems/disruptive behaviors, social skills, eating habits, and sleeping patterns. Behaviors to be observed and rated, however, can be selected from across the instrument, and is not limited by how the items are categorized. For example, the item, "Difficulty settling at night," is placed with behaviors that are often associated with anxiety. These behaviors may also be observed in youngsters who manifest other difficulties, such as hyperactivity, depression, or poorly developed social skills.

The purpose of inpatient/residential treatment is to reduce symptomatology; therefore, the instrument attempts to measure changes in undesirable (target) behaviors and negative symptoms. Items are not worded to measure improvement of desired behaviors, although a reduction in symptomatology should reflect an increase in positive or desirable behaviors.

With the exception of items measuring eating habits and sleeping patterns, all items are rated using a scale of severity: 0=not present, 1=mild, 2=moderate, and 3=severe. In turn, severity can be a measurement of three dimensions: intensity, frequency, and duration.

These attributes may be assessed individually or in combination. For example, a temper tantrum could be rated severe if the child is loud, out of control, and not responding to verbal interventions (intensity); several tantrums occur daily (frequency); the tantrum lasts an hour or longer (duration); or a combination of these activities. Specific descriptors, therefore, help determine how to rate the behavior.

The primary function of the CABRS is as a source for repeated (weekly, daily, shift-to-shift, or hourly) observations. The treatment team identifies behaviors it wishes to monitor during the treament-planning meeting. Typically, the team identifies specific behaviors related to treatment problems and objectives. Items 65 and 66 provide space to add behaviors not included on the checklist but for which the treatment team may choose to monitor using the same scale.

A team member identifies the behaviors to monitor from the Indicator Menu and documents them on the CABRS record form. Typically, 1–3 items suffice for each treatment problem or objective.

The rating system's purpose is to provide data on which to base continuing assessments of the youngster's response to treatment. The instrument does not replace data analysis. For example, if a behavior pattern is detected, this may suggest additional information is required, such as a situational analysis to determine factors that may elicit the behaviors. Finally, the data's utility can also be enhanced by using it with other information sources, such as anecdotal reports and the results of other assessment measures.

The purpose of inpatient/residential treatment is to reduce symptomatology; therefore, the instrument attempts to measure change in undesirable (target) behaviors and negative symptoms.

Developing the instrument involves addressing the following factors:

Utility. Data/information has utility if it aids decisionmaking. While developing this instrument, feedback was solicited from facility psychiatrists and psychologists about useful information in assessing a youngster's progress. This information was used to identify the behavioral indicators and the type of scale to employ. Review of the instrument by a work group and facility psychologists suggests the indicators incorporate the behaviors of interest to treatment providers.

Sensitivity. Sensitivity is the degree an instrument can detect and reflect differences. This is, in part, an attribute of the item and scale. For example, items that measure similar yet different behaviors should be worded in such a way that the observer can easily distinguish between the two. The scale should have sufficient gradation to capture differences in behavior along a continuum, and at the same time the response set should be mutually exclusive so the observer can easily distinguish between the categories.

A work group examined several response sets and determined fewer alternatives would probably produce greater agreement between observers. To enhance differentiation between the alternatives, definitions were provided and tested to ensure they are mutually exclusive. Facility psychologists and direct care staff, serving as primary observers/raters, conducted a review.

Reliability. Interrater reliability measures the extent that two independent observers agree in their behavior ratings when observing the same individual at the same time. The simplest measure of interrater reliability is the percent of agreement. Interrater reliability is enhanced through training and guidelines on which raters can base their assessments. To that end, descriptive statements are provided for each level in a response set. Observers should refer to these descriptors when preparing to observe and rate a behavior.

Pretesting was conducted by pairing employees and asking them to rate the same child on concurrent days. Pretesting of some (not all) items suggests a fair degree of interrater reliability. The initial results from this process indicate observers often made similar observations; when differences existed, they tended to be separated by one level. Seldom did one observer rate a behavior as not present or mild and the other rated it as severe. As with all observational measures, interrater reliability is enhanced through training and practice.

Validity. Validity is the extent to which the items measure what we purport or intend to measure. One of the first steps in developing the Child and Adolescent Behavioral Rating Scales was to examine other psychometric instruments used for screening and assessing children's mental health. This helped identify important constructs and item

formats. A work group reviewed the instrument during the development process and provided feedback to enhance face validity. Content experts—unit psychologists—reviewed the instrument to ensure the behavioral indicators included the behaviors they wanted to monitor (for example, content validity). Finally, several direct-care staff reviewed the instrument and provided feedback on the clarity of the items. These employees also piloted the instrument and provided feedback based on use.

The current edition of the CABRS has proven a useful adjunct to the way we monitor and assess behaviors in conjunction with treatment delivery. At the time it was developed, however, the average length of stay for the center's patients was considerably longer than current trends. The center's mission has shifted toward diagnostic evaluation and short-term, acute stabilization, and the length of stay needed to discern patterns and changes in behaviors has greatly diminished. For this reason, the instrument may be more practical for residential settings. Development of the instrument took place in a publicly funded facility, so it is in the public domain. The instrument is available online at www.ccca.dmhmrsas.virginia.gov/links.htm.

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Comfort Rooms: Reducing the Need for Seclusion and Restraint

by Gayle Bluebird

Among the many new approaches to reducing the use of seclusion and restraint, comfort rooms may be one of the most popular with psychiatric residents and staff.

Often created from unused seclusion rooms, comfort rooms (different from quiet rooms or time-out rooms) are being used as sanctuaries or for quiet time to reduce stress. The rooms are set up to be physically comfortable and aesthetically pleasing, with a reclining chair or sofa; walls painted in soft colors, such as peach or mint (rooms for children may be decorated with brighter colors); and themed murals selected by the individuals who will use the rooms. Using the room is voluntary. A staff member may be present in the comfort room if an individual desires.

It is important to clarify that the comfort room is not an alternative to seclusion or restraint; it is a preventive tool that may help reduce the need for seclusion and restraint.

Creating and using comfort rooms is not an entirely new concept. Multisensory rooms—also called sensory or sensory modulation rooms—are common in many psychiatric programs under the guidance of occupational therapists. The goal of the room is to provide a variety of sensorimotor activities to calm or awaken the senses (Champagne & Sayer, 2003).

Comfort rooms can reduce the use of seclusion and restraint through stress reduction. They are also cost effective and do not require any specialized education to create. Several Florida institutions have created comfort rooms for adults and children. Comfort rooms are also being developed in other parts of the country. Most staff at these facilities are interested in creatively designing other rooms for common use as well.

In 2003, the National Association of State Mental Health Program Directors added the comfort room concept to the Seclusion/Restraint Training Curriculum under the direction of Kevin Huckshorn. Today, many hospitals, including children's facilities, have established comfort rooms and added unique features and different approaches to using the rooms.

The first component to creating a comfort room is using a personal safety plan (formerly called the de-escalation form), sometimes called a crisis prevention form (LaBel et al., 2004. Jonikas et al., 2002. NETI, 2003). Many facilities find it helpful to include some variation of this assessment tool to help a resident child or young adult identify activities that may aid preventing a crisis. The form, filled out near the time of admission, also asks questions about what causes them to become upset—events or circumstances frequently referred to as "triggers." Special forms are used with younger children, employing illustrations that make it easier for them to identify their preferences, and using language they understand (NETI, 2003).

> ***The goal of the room is to provide a variety of sensorimotor activities to calm or awaken the senses.***

Information from the personal safety plan may influence the type of materials made available in the comfort room. Many children and young adults state that listening to music is helpful and may be specific about what types of music he or she prefers. For example, children or young adults may find it more calming to listen to loud rock music than to soft classical music. Other children or young adults might want to wrap themselves in a blanket with a teddy bear or read comic books.

Creating a comfort room can be a fun project. To ensure success, however, the project requires careful planning and is best completed in stages. First, an available suitable room should be determined. Ideally, the room should not be too large or small and should be located close to the nurses' station so the occupants' welfare can be checked. Formal monitoring is not necessary.

Determining the room's appropriateness for a given population is important. If the comfort room is created for children and young adults with self-injurious behaviors, it will need to be set up for extra safety, and the guidelines for usage may require more structure.

Administrative approval is necessary when setting up a comfort room. Top-level administration should be involved at all stages, including attending planning meetings. Identifying a "champion" organizer, who believes in the concept and has the tenacity to coordinate the project, will help promote its success.

Most important is involving the children and young adults who will use the room. They can help decide on wall colors, select mural images, and name the room. Youth will often choose names they find meaningful, such as the "Chill Out," or "Getaway Room." One private hospital created a room with fish motif and called it the "Fish Bowl."

Furnishing the comfort room is next. First—and most importantly—all furnishings and equipment for the comfort room should be thoroughly investigated for safety and comfort. For example, sharp implements should be avoided. Reclining chairs have worked for some facilities, but not for others. A few

facilities have had furniture custom-made, using materials that are durable, safe, and easily cleaned.

Another popular choice are bean bag chairs, which are loved by most kids and are inexpensive and easy to replace. Some facilities use sturdy rocking chairs, which do not allow for lying down or sleeping, but are also well-liked by children and young adults.

Lighting is another consideration. Being able to dim the lights is helpful. Special lighting may include black ceiling lights, neon lights, or lava lights. Music is essential for comfort rooms. It may be piped in to avoid loaning headphones, or some facilities use a tape player near a microphone at the nurses' station.

Comfort boxes, or comfort carts, may also be placed in or near the room. These are decorated boxes containing such items as stuffed animals, coloring books and crayons, crossword puzzles, reading materials appropriate for youth and children, and writing paper with pens or pencils. Cozy blankets may be provided or taken directly from the individual's bedroom. Other materials may be added according to a youth's wishes and if they are considered appropriate.

Once the room is set up, guidelines for using the room must be established. Obviously, the room should not be used during treatment hours or to avoid treatment. Time frames for how long a child can use the room may need to be established and a signup list created.

Facilities have used the comfort room concept in a variety of ways. Some have used it for family members to visit their children, and some have integrated it into program activities. One facility uses the room to perform assessments and complete personal safety plans. This allows for an introductory orientation to the room and is an excellent adjunctive use, considering most children and young adults are in groups or other treatment activities at the time of admission.

It is exciting to note that most facilities using comfort rooms come to recognize a need to change the entire institutional environment, including activities. Common rooms are converted into living rooms instead of day rooms, and walls are painted with bright colors or muted, soft colors. Resident artwork, identified with the artists' names (after permission is given), may be displayed in hallways and lobbies.

Other alternative healing approaches are also being implemented, including yoga classes, journal keeping, horticulture programs, and special arts projects. In some facilities, older children are even permitted to care for small pets.

Comfort rooms are still an emerging concept with many variations. As of yet, no studies have been conducted to show their value or even a correlation between their use and the reduction of seclusion and restraint. Similar to other new initiatives, comfort rooms require staff training and updates so the rooms are properly used and maintained.

Data analysts will have to use their technical expertise to prove the value of the rooms as methods of reducing the use of seclusion or restraints. It is possible, however, to measure satisfaction from children and young adults who used the room. Keep a sign-in book near the comfort room so people can record the length of their stay and comment how they used the room and if they found it helpful.

Finally, continue to ask what children and young adult residents believe is helpful when they are in crisis. Generally, their feedback is the most valuable tool available to modify a program and make it more effective.

Ultimately, the success of the comfort room and other projects will depend on the reactions of those who use them. From these individuals, we will learn if a more homelike and holistic environment is helpful in their treatment and recovery.

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Child Care Workers First in North Carolina to be Certified

by BCH Communications

It's been a long day for Kennedy Home child care worker Teresa Harper. She has helped the girls under her supervision at Blackwell Cottage with homework. She has coaxed them to do their chores. And now she lends her ear, listening as each girl recounts her day. Soon the girls will turn in for the evening, and Harper wishes she could do the same. But her day is not finished.

Harper is participating in a specialized program that will certify her as a professional child care worker, and her class assignments are due in the morning. The clock creeps towards 3:00 a.m. when Harper sets her materials aside. She believes all of her hard work is worth it. She looks forward to dispelling the notion that her job is babysitting. She dreams that others will one day view her job as a profession—the profession she always knew it to be.

Harper and fellow Kennedy Home child care workers Darryl Hines and Howard Smith are not only the first Baptist Children's Home of North Carolina employees to receive professional child care certification, but they are the first child care workers to be certified in North Carolina. The three were certified as family and child welfare practitioners at the Children and Family Services Association—North Carolina's (CFSA-NC) annual meeting in Raleigh last October. Each completed an extensive training and certification program through the National Center for Professional Certification (NCPC), in Georgia.

The training, sponsored by CFSA-NC, is part of a pilot project sponsored by the Duke Endowment. Certification for child care workers is currently not an employment requirment in the state.

From left: Chip Theriault, Howard Smith, BCH President Michael C. Blackwell, Teresa Harper, Linda Krueger, and Darryl Hines at the Children and Family Services Association's annual meeting in Raleigh, North Carolina.

"It's been a great honor to do this," Harper says of her job as a child care worker for 13 years. "I don't think people understand that what I do as a child care worker involves a process, strategy, and techniques. It is a profession."

The three child care workers were eager to participate in a program that provided professional validation for their work and hopefully will enhance people's perceptions about the responsibilities of child care workers. "This is the best thing that has happened to me in my 13 years at Kennedy Home," Darryl Hines says. "People will view us differently and see that what we do is both a profession and a ministry."

Howard Smith, a child care worker for eight years, agrees. "This is the final frontier as a child care worker. It gives significance. It helps everyone else to understand just how important the work we do really is."

The three participated in the training with other child care agencies. Each agency determines its own pace in completing the program. BCH finished first, in just eight months. Like Harper, Smith and Hines devoted a tremendous amount of time to the training.

"Honestly, I got frustrated sometimes because I couldn't find the time to fit all the extra work in," Hines admits. "I found myself asking God to give me strength, and He helped me make it through this course."

The coworkers also leaned on each other, working together to encourage and help one another. "We have always been friends, but this brought us even closer together," Smith explains. "These two have taught me a lot, and we accomplished this as a team."

Their team also included two other

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Point/Counterpoint

Q: *Should residential program staff become adoptive, foster, or visiting resources for children in their programs?*

POINT:

Staff with experience working with troubled children/youth are valuable resources as potential adoptive, foster, or visiting families for children in their program.

by Charles P. Conroy

A group of kids is playing soccer on a beautiful autumn afternoon at a large school and residential treatment facility in New England. The staff stands on the sidelines and eagerly cheers on the boys, residents from two or three of the facility's homes on its 100-plus acre campus. Included are the three Vasquez brothers, Jack, Joey, and Jim, ages 8, 9, and 11. The "JVs," as they are known, will soon be discharged. One by one, they are scheduled to move in with a new foster father. He also happens to be the school's director.

The game isn't that rough, but one of the players is knocked to the ground. A whisper goes through the crowd of staff spectators, "Uh, oh, is that a Vasquez!" The staff wondered what an injury to one of the soon-to-be foster sons of the CEO would mean. Revenge? Allegations of lack of supervision? Mass firings? The possibilities were numerous and ominous. After all, these three were the foster sons of the boss!

As it turned out, the boy knocked down wasn't hurt. To everyone's relief, he wasn't a Vasquez, so the perceived threats to the staff never materialized. The vignette points out, however, a potential problem when a child welfare agency staff member (CEO or not) takes on the role of foster or adoptive parent for a child in the same agency.

Are there built-in problems with such an arrangement? Should staff be discouraged when they express interest in providing a more permanent family arrangement for kids in their care? Does it make a difference if the prospective foster/adoptive parent works directly with the child in question? What potential conflicts might arise? How will other staff react? How will other kids in the same program (many of them

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COUNTERPOINT:

Professional boundaries should preclude staff from being considered as adoptive, foster, or visiting families for children/youth in their programs.

by Stephanie Dressin Johnson

To effectively work with youth in foster care, staff members must maintain professional boundaries, while still fostering therapeutic rapport. Upholding appropriate boundaries is important for many reasons.

Staff members must maintain unbiased opinions in their assessments of a client's case and treatment plan. If a staff member has a personal relationship with a client, it is difficult to remain neutral and to make unprejudiced decisions about what is in the client's best interest.

For example, the staff member might be drawn into aligning with the child against other professionals, such as a therapist, thereby allowing the client to split the adults involved. If the client is no longer appropriate for the program, the involved staff member may have a hard time accepting this and may advocate the client stay despite the treatment team's assessment. It is natural human behavior to become protective, at great lengths, of those we love. How can a staff person truly be impartial in working on the case of a client whom they parent and with whom they live?

Another problem with the type of relationship in question is the potential for transference issues to interfere with the client's clinical progress. Can a client grow clinically from a counselor or therapist who is also mom or dad? Clients may have a difficult time working in therapy, in groups, or in the milieu on issues from their past if their primary caretaker is facilitating that process.

In addition, the client may experience confusion about what hat the staff person wears and at what time. When the client comes into the program after school, for example, can

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without families) react to seeing a staff member single out one child for personal attention and commitment?

Maybe it's just too complicated to deal with. The need to address all of these questions might suggest this is not a good idea. Maybe residential facilities staff should simply be barred from becoming foster or adoptive parents for kids in their facilities.

That's the easy answer, but as H.L. Mencken said, "For every complex problem, there is a simple answer. And it's wrong."

There are clearly potential problems with residential staff becoming foster or adoptive parents. Favoritism and conflict among kids or staff is possible, but that's no reason not to go forward if a staff member expresses sincere interest and commitment. The program team has to examine the request and see if it's a good fit and then put in place the necessary safeguards for the child, the prospective parent, and the other kids in the program.

It's important to remember that as the foster or adoptive plan unfolds and takes shape, another agency, usually the state child protective department or a contracted agency, will be involved. It can provide an additional set of eyes to ensure the placement is realistic and potentially successful. So, there's another safeguard.

Why foreclose on the possibility of having a person who is trained and has chosen child welfare work as his or her vocation, to become a foster or adoptive parent? It is counterintuitive.

Adults who have chosen child-oriented careers are obvious choices to be foster or adoptive parents. Personality, temperament, history, and interactions with kids would certainly be factors to examine, but it strikes me that people working with kids should have a leg up on foster or adoptive parenting.

Those of us in this kind of work have experience and a record of interactions with kids, factors often missing in people who volunteer to become involved with kids for the first time. Residential staff, steeped in practical experience, also have realistic expectations. They understand the complexity of kids who leave residential facilities. Untutored foster or adoptive parents, on the other hand, can be blinded to realities by their altruism—laudable though it may be.

A mismatch of parent and child is considerably less likely when the foster or adoptive parent has previous knowledge of the child and has made a decision based on experience and a belief that he or she will hit it off with this specific child. Often foster or adoptive placements start cold and are based on a vague feeling, thought, or inclination to do something to help a child.

Child welfare facility staff goes through a long, deliberative process based on the needs of a specific child (whom they know), and they are generally informed by their experience with children. Their decision is not based on a general feeling of wanting to do something nice for a child, but a feeling of wanting to do something for this particular child. In other words, the decision is child-specific.

What appear to be obstacles at the beginning can be worked out if the program team is closely involved, focuses on the needs of the child, and views the expressed interest of the staff member in the same way they would any other prospective foster parent. Vigilance, team collaboration, and careful attention to the needs of all involved, including the other children who are watching closely, can make it all succeed.

We owe it to children to have as many viable options as possible when it comes to foster and adoptive care. Trained child welfare agency staff are perfect candidates. One might even ask, "Who better?"

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she sit and talk to that staff person to process her day as she would at home, or is mom not allowed to be mom until after 6:00 p.m.?

The same principle applies to the home environment. The client may not be able to truly feel comfortable and let go of the staff-client role. The boundaries are too enmeshed, and they diminish a person's effectiveness in two extremely important roles. This is likely the reason most schools will not allow a student to be in his or her parent's classroom or attend a school where his or her parent is the principal.

There are other reasons for upholding professional staff-client boundaries. Learning to respect relationships with professionals, such as counselors, teachers, tutors, and coaches, is important in social skills training. Breaching those boundaries can be risky.

Appropriate boundaries and good documentation can protect staff against false allegations. Agencies with comprehensive written policies and procedures relating to appropriate staff/client boundaries also limit the opportunities for staff to display poor judgment in their interactions with clients. Clients and staff are both protected by a safe, professional, therapeutic relationship.

Finally, we need to consider the effect this type of arrangement may have on other clients in the agency. How does a staff member explain why he or she picked one particular client to visit, to bring into his or her home, or to adopt? Other clients would certainly view this as favoritism, thereby influencing that staff person's effectiveness with those clients. Another issue is staff selecting the "nice and cute" clients who are well liked, while the "bad" kids are left behind. Additionally, these situations would create precedents, and clients would compete to be chosen, or expect that all staff members should follow suit. Clients or other staff members may view staff as selfish or pretentious for choosing not to foster a relationship with clients outside of work.

It's easy to say, "Why should we turn down anyone who is interested in being in the lives of these neglected children?" The cost, however, is a possible breakdown of services, role confusion, fostering an inability to recognize appropriate boundaries, risks of allegations, favoritism, and more. The cost is not worth the damage that can be done to a client, his treatment, an agency, and even the realm of foster care.

Stephanie Dressin Johnson is a consultant with the Adolescent & Family Growth Center, Springfield, Virginia.

In the next Point/Counterpoint...

Question:
Can sex offenders be served within the community?

Point:
Sex offenders require a level of intensity that can best be provided within campus-based or self-contained programs.

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

CWLA 2005 CONFERENCES

2005 Juvenile Justice National Symposium
Joining Forces for Better Outcomes
Miami, FL•June 1–3

2005 Western Region Training Conference
Realities, Risks, Rewards
Pasadena, CA•June 20–22

New England Region Training Conference/National Child Care and Development Summit
Sparking a Renaissance: Making Children a National Priority
Providence, RI•September 28–30

For information, visit
www.cwla.org/conferences

CHILD CARE WORKERS, from page 7

participants who received training on a different level. Linda Haynsworth-Krueger, BCH's Kinston Area Family Services Director, and Chip Theriault, Thomasville Area Family Services Director of Clarification and Emergency Services, have been certified by NCPC as assessors. Their specific training allows them to train other child care workers to receive professional certification. BCH will train more child care workers in the coming months. Becoming professionally certified has not only equipped the child care workers with a special set of credentials, it has given them a new outlook on their work with children and families.

"Because of my training, I am considering furthering my education in this field," Hines says. "Being a child care worker is something I must do. And I have worked hard to do. There are some lives I have to help change."

This article first appeared in the December issue of Baptist Children's Homes of North Carolina (BCH) publication Charity & Children. For more information, contact W. James Edminson at 336/474–1217 or wjedminson@bchfamily.org.

The National Center for Professional Certification (NCPC) is a national nonprofit organization that provides certification for direct care workers as well as supervisors and managers in residential and community-based service programs. NCPC provides training and portfolio assessment of competency. For more information: www.ncpconline.org or 706/221–1990.