

RESIDENTIAL GROUP CARE QUARTERLY

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CWLA's Position on Residential Care

To promote better services and outcomes for children, youth, and their families, CWLA strongly endorses a system of care that includes residential services as an integral component of the continuum of services.

The Issue

The original use of *continuum of care* used least restrictive and most appropriate as the accepted standard. The continuum included services such as prevention and diversion, family preservation, counseling, in-home services, day care, day treatment, foster care, adoption, residential treatment, family reunification, transitional care, and aftercare. In the last 20 years, however, child welfare practice has created a linear notion of *continuum of care* as a case management blueprint governing most decisions.

Currently, the child welfare field widely accepts that the most humane and efficient approach to allocating services to children and families is to provide those services from least to most restrictive, as this stepwise intervention is presumed to cost less and keep families together. This practice has resulted in residential services being used as the intervention of last resort, often after multiple failures in other services, rather than as the most appropriate intervention based on a thorough assessment of the individual child and family's needs.

Support for Residential Services in the Continuum

Residential services are an integral component within the multiple systems of care and the continuum of services. Residential services include supervised/staffed apartments, group homes, residential treatment, intensive residential treatment, emergency shelter, short-term diagnostic care, detention, and secure treatment.

Residential care's primary purpose 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 services provide educational, medical, psychiatric, and clinical/mental health services, as well as case management and recreation (CWLA, 2004).

Residential settings offer children and their families a variety of services, such as therapy, counseling, education, recreation, health, nutrition, daily living skills, independent-living skills, reunification services, aftercare, and advocacy (Braziel, 1996).

A number of studies have identified positive outcomes associated with residential care. A Canadian study of 40 children in residential care found that for most children, functioning was severely impaired at admission, moderately impaired at discharge, and

normal at one and three years post-discharge (Blackman, Eustace, & Chowdhury, 1991). A study of children diagnosed with conduct disorder in residential care found that the number of concerns expressed by caregivers decreased from admission to discharge, and six months, one year, and two years postdischarge (Day, Pal, & Goldberg, 1994).

Finally, a retrospective study of 200 children served at group homes in the Midwest found that, as adults, 70% had completed high school, 27% had some college or vocational training, and only 14% were receiving public assistance (Alexander & Huberty, 1993).

Family-centered residential care has shown considerable success. Landsman,

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Groza, Tyler, and Malone (2001) found that youth in family-centered care had shorter lengths of stay, were more likely to return home at discharge, and had better long-term stability than did youth in traditional residential care. Similarly, at 6-, 12-, 18-, and 24-month follow-up, 58% of youth discharged from family-focused, community-oriented residential programs had been involved in no new illegal activity, had continued to participate in educational endeavors, and had not been moved to more restrictive levels of treatment. Ninety percent of the youth accomplished two of the three aforementioned outcomes (Hooper, Murphy, Devaney, & Hultman, 2000).

One of the most promising studies demonstrating the efficacy of residential care with young children emerged from a 23-year longitudinal Israeli study. Weiner and Kupermintz (2001) found that 268 children initially placed as preschoolers in well-designed residential care settings, some of whom spent long periods in care before being placed in adoptive homes, functioned "adequately or as well as young adults."

The finding was contrary to the researchers' initial hypothesis and led them to conclude that "neither pre-

school institutional care, nor long-term institutional care was found to be harmful for these young people in terms of normative living. In fact, the majority of those who were functioning well have significantly improved since their teenage years."

Characteristics of residential care that have been correlated with long-term positive outcomes include high levels of family involvement, supervision and support from caring adults, a skills-focused curriculum, service coordination, individualized treatment plans, positive peer influences, enforcement of strict codes of discipline, a focus on building self-esteem, a family-like atmosphere, academic support, presence of community networks, a minimally stressful environment, and comprehensive discharge planning (Pecora, Whittaker, Maluccio, & Barth, 2000; Curtis, Alexander, & Lunghofer, 2001; Whittaker, 2000; U.S. General Accounting Office, 1994; Curry, 1991; Lazelere et al., 2001; Barth, 2002).

Age, gender, intelligence, length of stay, and presenting problems all are weakly correlated to outcomes (Curry, 1991; Pecora et al., 2000).

Unfortunately, outcome studies of residential services vary widely in scope

FEEDBACK

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and suffer from an absence of control conditions, poorly defined service units, limited samples, improper selection of outcome criteria, and utility by practitioners (Whittaker & Pfeiffer, 1994).

Those studies that do identify a comparison group often fail to control for the initial level of problems the children present, making causality especially difficult to determine. Such gaps in research have posed a barrier to identifying best practices in residential services, which are exacerbated by the relative inattention by federal agencies and private foundations to new models of residential provision, compared with other types of out-of-home placement (Whittaker & Maluccio, 2002).

Recommendations

To achieve more effective, efficient systems of care for children, youth, and families, both the agencies developing and controlling public policy and the service providers delivering the services need to work cooperatively.

Recommended steps include:

Public Policy

- Conduct initial and ongoing coordinated assessments in which the operative question is not, “Where does the child and family fit into the system?” but rather, “Which services in the system best fit the child’s and family’s strengths, needs, and permanency plan at the time?” This would include assessing the supervision required to ensure the safety of the child and those with whom the child interacts; the interventions and supports necessary to ensure treatment needs are met; and the developmental needs of the child and family system. Residential treatment would be used as the treatment of choice, if so indicated by this comprehensive assessment.
- Promote the choice of most appropriate and least restrictive service for children and families, investing in time-limited intensive interventions at the outset and throughout the course of care if assessment dictates this is the best choice for dealing with trauma and/or keeping families together over the long haul.

- Revise policy and practice to acknowledge that some children and families will require services at various levels of intensity over time, and this may be a decidedly nonlinear process. The goal is to provide appropriate (including appropriately limited) interventions at various points in time; design each intervention as part of a continuous strategy of family stabilization so that past, present, and future interventions shape each other; and manage helping resources for each family over time rather than seek quick-fix solutions.
- Retain an emphasis on family empowerment and family connections at all levels of service, recognizing that optimum connections may not mean every parent and child live together full-time or without ongoing support.
- Ensure the provision of care and support to families after the course of intensive services as a way of preventing costly future interventions as much as possible.
- Blend services so there are step-up, step-down, and wraparound options at all levels of intervention, and, in particular, so the boundaries between home-based and out-of-home services are eliminated.
- Develop outcomes, including cost-benefit measures, not limited solely to discrete services but to long-range family stabilization and the real cost of services across time.
- Develop rate reimbursement methods that include all direct and indirect costs associated with providing quality care, treatment, and services.

Service Providers

- Implement programs and practices that actively support family-centered services that maintain permanent family connections for all children.
- Develop new, structural partnerships among residential services providers, referral and funding agencies, foster care and postadoption services, public schools and educational collaborators, and in- and outpatient mental health providers to allow for

greater access by all children, youth, and families to all of the services along the continuum at any given point.

- Increase capacity to provide services to those children and families with the most intensive needs.
- Commit resources to postdischarge continuity of care and provision of family supports for at least one year after children exit residential programs. Resources could include new professional opportunities for campus-based child care workers to learn how to be available to families in the community both during and after treatment.
- Develop more flexible methods of providing services and the duration of residential placement with much more of a presence in family homes, local schools, and other community resources.
- Develop universal outcomes to measure the effectiveness of residential services, including areas such as:
 - *Clinical–Difficulty of the Child, Difficulty of the Family, GAF; Child Needs Checklist, Family Needs Checklist; and
 - *Functional–Education, Employment; and
 - *Recidivism–court and re-abuse.
 - *Effectiveness–Restrictiveness of Placement, Nature of Discharge, Permanency Planning; and
 - *Consumer Satisfaction–Child over 12 years, Parent, and Referring Entity.

References

- Alexander, G., & Huberty, T. J. (1993). *Caring for troubled children. The Villages follow-up study*. Bloomington, IN: The Villages of Indiana, Inc.
- Barth, R.P. (2002). *Institutions vs. foster homes: The empirical base for a century of action*. Chapel Hill: University of North Carolina, School of Social Work, Jordan Institute for Families.

The View of Adolescent Life: Perceptions and Realities

by Lisa Moore Willis

The tragedy at Columbine High School brought visibility and focus on adolescents like never before. This single incident created a vehicle for discussion, media coverage, and debate on the state of America's adolescents.

Unfortunately, the headlines, news stories, topics of debate, legislation, and kitchen-table talks all focused on the negative, creating a perception that today's teenagers are reckless, violent, and out of control. Teenagers became the poster children and single focus for explaining the root of what was wrong in America. What creates the current view of adolescents in America, how do teenagers feel about themselves, and what can be done to create a clearer, more accurate perception?

Development of the Adolescent Image
Perspective is defined in the *American Heritage Dictionary* as "subjective evaluation of relative significance; point of view." If one's perspective is subjective to what is relative, where is our relativity of youth issues based?

In a study commissioned by Children NOW, Dale Kunkel (1994) says

"Much of America depends on the news media to shape their perception about the conditions of children. How we as a nation perceive children and how we devise policies and laws that affect them depends largely on how the news media covers children's issues."

Ken Sanes (1999) examines the manipulative nature of news media coverage of events in his online publication, *Image and Action: Deconstructing the News*:

"It is the story that gives everything else presented and described its

meaning. [It] shows the connection between the things. The story creates a framework of meaning, a model that allows us to perceive (or believe we perceive) larger situations, and not merely scenes and actions."

This description explains how a journalist creates a story by connecting a series of single events to create an image of a whole for the viewing public. Knowing the definition of perspective, and how journalists manipulate events to create an image, creates a framework for understanding how perceptions of adolescents develop.

Sanes (1999) says the media "...can evoke our acts of identification and disidentification, causing us to see some people and characters as fellow sufferers, heroes and saints, and others as wrongdoers or pathetic souls. They use the full repertoire of image manipulation techniques, crediting and discrediting in symbolically rich depictions, to evoke these responses. Journalists write outrage stories about the persecution of victims, in which they get us to hate the perpetrators and put ourselves in the shoes of the victims. They evoke primal responses of sympathy and hate, and a desire for revenge. Politicians give speeches that 'demonize' opponents, to accomplish the same thing. All are busy creating a world full of 'us' and 'them' in which 'we' are good and 'they' are bad."

After the shootings in Littleton, Colorado, at Columbine High School in 1999, the media placed extreme focus on adolescents. Considering Sanes's description of journalism and how a "framework of meaning" is developed, a strong foundation for demonizing ado-

lescents was built by the media. The news coverage portrayed a series of horrific images in a holistic context, creating a perception that the story was normal at U.S. high schools. This approach created a societal view of adolescents based on the actions of Eric Harris and Dylan Klebold.

Youth Vision (Males, 1999) found, "While some respondents attributed their negative perceptions of youth to personal experiences, most said that media (especially TV news) played a vital role in informing their opinions." Author Mike Males (1999) conducted a survey of ordinary citizens in Orange County, California, to assess perceptions of teens. The survey asked people ages 19–80 what percentage of crime is attributed to teens. On average, participants answered 65%. In reality, teens carry out only 13% of crimes.

So why does teen crime, including violence, drugs, and other illegal acts, seem so widespread, even overwhelming? *Securing the Future for Safer Youth and Communities*, a report by the National Crime Prevention Council (1998), attempted to answer this question:

"One reason is that media reporting on violence has increased. Though crime went down consistently between 1991 and 1995, news reporting of crime increased four-fold. Nightly news broadcasts bring violent crimes from across the nation into our living rooms. Stories about the heroes of daily life, whether teens or adults, show up far less often than stories about gun battles over gang turf. This distorts our view of how much youth crime there actually is."

Positive Versus Negative Images

How do perceptions affect feelings towards adolescence? Robert Hill (1992) illuminates the negative feelings towards teenagers in a journal article reviewing two recent studies. The first was a survey asking 103 first- and second-year medical students: “When the word ‘teenager’ or ‘adolescent’ is mentioned, what is your first image or impression?”

Negative images were those emphasizing teens in trouble due to sex, drugs, law breaking, suicidal actions, delinquency, or mental and behavior problems, as well as less serious but still negative images portraying teens as confused, lazy, rebellious, immature, irresponsible, spoiled, silly, or ugly. More than half (58.3%) of the medical students’ responses fell into this category. Positive images, characterizing teens as good, nice, energetic, hard working, fashionable, moral, responsible, or idealistic, accounted for only 3.9% of the total responses.

The second study Hill reviewed reflected similar statistics. The study asked various groups to respond to the same question asked of the medical students. The positive versus negative responses by group included: Leadership Oklahoma members: 44.4% negative, 12.7% positive; Southern Baptist Church members: 44.3% negative, 12.5% positive; and union members: 59.5% negative, 9.5% positive. Adult perceptions of adolescents, therefore, are negative, regardless of geography, age, education, or gender.

Author Robert Enright (1987) also explored why adolescents are viewed negatively and incur the brunt of prejudice: “Whether youth will be portrayed as competent to assume adult roles, or as psychologically incapacitated to warrant their exclusion from adult roles, will depend largely on the labor and economic requirements of the society in which they live.”

This fact is illustrated in American history. Compulsory school attendance laws were enacted during the 1930s. For the first time, teens were expected to stay in high school and not compete for scarce jobs. In today’s tight financial climate and record level layoffs, renewed

jockeying for precious few jobs adds to the negative perceptions of youth.

Today’s society does not view teens as necessary workers with useful skills. This view, coupled with the negative focus by the media, creates an environment that greatly decreases adolescents’ capacity to succeed. Discussing the ramifications of such perceptions, Enright says

“There is a strong correspondence between the ideas of adolescent psychology and the legislation passed by the U.S. Congress. We may impute too much truth-value to it. We may use the idea as an ultimate authority in determining social policy for youth.”

If elected officials’ perceptions about teens are the same as those of everyday adults, new policies and funding decisions will react to those perceptions.

The perceptions held by adults in this country do not coincide with the images and feelings adolescents hold about themselves.

For example, on the anniversary of the Columbine shootings, President George W. Bush warned that the nation “must face up to the plague of school violence, with an average of three million crimes committed against students and teachers inside public schools every year.”

Certain buzz words and inaccuracies in this statement build a very negative perception of adolescent youth and will influence legislation based on teens as violent offenders. The term *plague* suggests teens are a significant public health issue we should fear.

Referring to “three million crimes committed against students and teachers” suggests they were all violent offenses similar to Columbine. In fact,

the figure includes lost property, presumed thefts, threats, or unwanted gambling—hardly violent offenses warranting plague status. Finally, the President stated that such violence lives “inside public schools,” suggesting public schools are filled with violence.

Society must face adolescent issues holistically. The individual teenager is often the focus target, not their environment. According to Hill and Fortenberry (1992)

“By exploiting the cultural stereotype of adolescence as an age-based disorder inherent to teenagers, adolescent medicine specialties may unintentionally draw attention away from more important bases of youth morbidity and mortality: racism, the juvenilization of poverty, underemployment, inadequate education, and declining per-capita resources for dependent children and youth.”

Sanford A. Newman, President of Fight Crime: Invest in Kids (Myers, 1999), says the obsessed focus on the Littleton shootings represented misplaced priorities. “In an average week, 40 kids are killed by violence. That’s over 150 Littleton’s a year. And Males explains that, “Ninety-eight percent of the children killed by violence are killed outside of school.”

Teenagers’ Self Perceptions

The perceptions held by adults in this country do not coincide with the images and feelings adolescents hold about themselves. In a survey of 620 youth, ages 13–18, the Barna Research Group of Ventura, California (1998) discovered “the widespread talk about teenagers as ‘slackers’ and ‘pessimists’ is borne of adult perceptions, but does not at all seem to mirror the self-perceptions of teenagers.”

When Barna asked teens how adults view them, the adjectives teens believed adults would select included, “lazy” (chosen by 84%), “rude” (74%), “sloppy” (70%), “dishonest” (65%), and “violent” (57%). Asked to describe themselves, teens responded with “happy” (selected by 92%), “responsible” (91%), “self-reliant” (86%),

“optimistic about my future” (82%), “trusting of other people” (80%), “very intelligent” (79%), “physically attractive” (74%), and “seen by others as a leader” (69%).

Are youth delusional or are adults missing something?

Marian Salzman of BKG Youth (Meyers, 1994), a teen marketing research organization, says, “It’s a myth that teens care only about themselves. Teens of all ages have evolved into an eco-generation that values quality, durability, and value. Simplicity is big, wholesomeness is back, and concern for common causes is par for the course.” Salzman also explains “teens are not materialistic, but ... hardworking and turned off by the consumerism of recent years.”

Another common misperception about teens is that they hate their parents and rebel against family norms. On the contrary, teenagers desire quality time with their parents. In April 2005, *U.S. News and World Report* released a special edition titled *Mysteries of the Teen Years*, including an article sharing survey results of how adolescents view their relationships with their parents. Seventy-seven percent of teens surveyed said they get along extremely well or very well with their parents; 86% gave their parents an A or a B for the job they were doing to raise them; and 80% said they enjoyed spending time with their parents.

Changing Negative Perceptions

“On a clear day you can see forever,” and “I can see clearly now, the rain is gone,” are song lyrics reflecting how America needs to begin viewing adolescents. The storm clouds of misperceptions, innuendo, and inaccuracy need to be washed away and clarity of sight, approach, and purpose to shine through. It can be done. The key to changing negative perceptions of adolescents lies within the mass media.

A document published by the National Clearinghouse on Families and Youth, *Covering Youth and Family Issues: A Guide for the Media* (1997), states

“Without question, the media play

a critical role in informing communities about the problems facing youth and families. Yet the media also play another, far more powerful role: helping communities to view young people as a resource. Even youth growing up in considerable distress have talents, strengths, hopes, and dreams. With the support and guidance of caring adults, they can become contributing members of the community.”

According to the authors, who studied more than 30,000 adolescents, “The overriding finding of our research over the years has been that about 80% of adolescents are normal and function well.” If television news and newspapers could highlight this 80%, then maybe public policy would address the needs and successes of this 80%, and our children would thrive and our communities prosper.

U.S. News and World Report has played a role in helping communities by publishing a special edition on the teen years with an emphasis on debunking the myths of adolescent life created by media coverage and providing research that dispels negative perceptions. As youth development professionals, leaders in our community, parents, aunts, uncles, and grandparents, we must take the time to learn the truth about adolescent development and truly get to know the teens in our life. We must take the time to educate others about the vital assets we have in our communities—adolescent youth.

References

- Adults possess a radically different view of teenagers than teens have of themselves.* (1998). Available online at www.barna.org. Ventura, CA: The Barna Group.
- Covering youth and family issues: A guide for the media.* (1997). Available online at www.ncfy.com. Silver Spring, MD: National Clearinghouse on Families & Youth.
- Enright, R., Levy Jr., V., Harris, D. & Lapsley, D. (1987). Do economic conditions influence how theorists view adolescents? *Journal of Youth and Adolescence*, 16(6), 541–557.

- Hill, R., & Fortenberry, D. (1992). Adolescence as a culture-bound syndrome. *Social Science & Medicine*, 35(1), 73–80.
- Kunkel, D. (1994). How the news media see kids. *Media Studies Journal*. Available online at www.freedomforum.org. Arlington, VA: The Freedom Forum.
- Males, M. (1999). *Framing youth: 10 myths about the next generation*. Monroe, ME: Common Courage Press.
- Meyer, L. (1994). *Teen speak: A bewildered parent's guide to teenagers*. Princeton, NJ: Peterson's Guides.
- Myers, J. (1999). Columbine's shadow shades U.S. budget. *Youth Today*, 9(1), 9–10.
- Mysteries of the teen years [Special issue]. (Special Issue, 2005) *U.S. News and World Report*.
- National Crime Prevention Council. (1998). *Securing the future for safer youth and communities*. Available online at www.ncpc.org.
- Offer, D., & Schonert-Reichl, K. (1992). Debunking the myths of adolescence: Findings from recent research. *Journal of the American Academy of Child and Adolescent Psychiatry*, 31(6), 1003–1012.
- Paddock, R. (1994, March 1). Children say media give negative view of youth. *Los Angeles Times*. Available online at www.latimes.com.
- Sanes, K. (1999). *Image and action: Deconstructing the news*. Available online at www.transparencynow.com.

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Assessing Youth Preferences for Adult Behavior in Residential Care: A Replication

by Jack T. Bowers III, Robert J. Jones, Gary D. Timbers, and Nancy Mamlin

During much of the 20th Century, most U.S. residential care and treatment agencies gave little thought to the measured effects of their programs on their youthful clients, or to the opinions of those clients about the care and treatment they were receiving.

Then, in the late 1960s, a blizzard of data-based studies began to appear in the literature, many in the then new *Journal of Applied Behavior Analysis* (JABA), concerning the efficacy of a new residential intervention program for problem teens—Achievement Place. The late Montrose M. Wolf, founding editor of JABA, was the seminal inspiration for this learning-focused approach to the problems and skill deficits of teens in residential care.

Among its defining characteristics, the Achievement Place approach, later known as the Teaching-Family Model (TFM), favored the systematic teaching and reinforcement of new and more adaptive youth skills. The approach and its constituent elements arose directly from the emerging field of applied behavior analysis and the tenets of social learning theory.

During ensuing decades, hundreds of residential programs nationwide adopted and adapted the precepts of the TFM in residential programs for kids presenting an array of behavioral, emotional and, more recently, medical problems. This persistent advance of the TFM technology has been paralleled, over the same interval, by a steady stream of studies and commentary aimed at refining and extending the purview of the TFM (Fixsen & Blase, 2002). Today, the TFM is an internationally recognized, widely applied, and broadly documented program of skill-based care and treatment operating

within the Teaching-Family Association (www.teaching-family.org), a growing professional organization.

Preferences for Caregiver Behavior

Over the years, there have been many key developments within TFM. One of the most important and durable has been the systematic application of empirically determined youth-preferred adult behaviors by direct care staff, called Teaching-Parents or Family Teachers. These youth-preferred behav-

embrace, imitate, and internalize what they learned.

Since the publication of Willner's results, direct care practitioners in TFM programs have been selected for their natural comfort with Willner's youth-preferred adult behaviors, trained in the use of *quality components* based on those preferred behaviors (and to avoid the use of non-preferred behaviors), and regularly evaluated to ensure their consistent use of those quality components.

The Willner Data Revisited

This article summarizes the results of a direct replication of the Willner research concerning the identification of youth-preferred behaviors. Unlike most direct replications, however, this one does not challenge or confirm the veracity of the data produced by the earlier study. Willner's study was conducted competently. The results were not only compelling, they have been widely applied for almost 30 years.

We undertook our replication to determine if the original findings have changed as a result of dramatic differences in today's media environment compared to media viewed by youth a quarter-century ago. We reasoned that the adult behaviors Willner's *Leave It to Beaver*-era subjects grew up with have been significantly replaced by adult role models in the media prone to and often rewarded for behaviors leaning toward anger, intimidation, aggression, and violence. We were also concerned about the increase in the sheer density of youth exposure to media portraying adults behaving badly.

Rationale for the Replication

Indeed, changes in the media environment consumed by American

We undertook our replication to determine if the findings have changed as a result of dramatic differences in today's media environment compared to media viewed by youth a quarter-century ago.

iors were the principle product of research conducted during the mid-1970s (Willner, et al. 1977) and included such behaviors as calm and pleasant voice tone, positive feedback, fairness, joking (non-sarcastic), and concern.

The study also identified specific adult behaviors youthful subjects did not like—shouting, blaming, unpleasant physical contact, insulting remarks, expressions of anger, and cursing. In terms of using their data, Willner and his colleagues reasoned that if caregivers adopted the preferred behaviors they had empirically documented and avoided behaviors their subjects disliked, they could help their clients better retain,

TABLE

Comparable Behavior Categories Between Both Studies

Behavior Categories from Present Study	Scores						Behavior Categories from Willner's Study
	Youth(a)	Boys(b)	Girls(c)	Youth(a)	Boys(b)	Girls(c)	
Calm/pleasant voice tone	3.55	3.25	3.80	3.80	4.00	3.60	Calm/pleasant voice tone
Being playful	3.55	3.25	3.80	3.60	3.75	3.40	Joking
Being fair	3.44	3.00	3.80	3.60	3.25	3.80	Fairness
Helping	3.33	3.50	3.20	3.70	3.50	3.80	Offer to help
Smiling	3.33	2.50	4.00	3.00	3.00	3.00	Smiling
Showing concern	3.22	2.50	3.80	3.40	3.00	3.80	Concern
Showing courtesy	3.11	2.25	3.80	3.30	3.00	3.60	Politeness
Making eye contact	2.55	1.50	3.40	2.40	2.75	2.20	Eye contact
Point giving	2.44	1.75	3.00	3.50	3.35	3.60	Point giving
Supportive physical contact	2.11	1.75	2.40	2.40	2.50	2.40	Pleasant physical contact
Showing anger	0.77	1.50	0.20	1.10	1.50	0.80	Anger
Being rude	0.55	1.00	0.20	0.90	1.20	0.60	Unfriendly
Being bossy	0.44	0.25	0.60	0.70	1.00	0.40	Bossy-demanding
Name calling	0.44	1.00	0	0.50	0.50	0.50	Mean insulting remarks
Blaming	0.44	1.00	0	0.10	0.25	0	Accusing-blaming statements
Cursing	0.33	0.75	0	1.00	0.50	1.40	Profanity
Complaining	0.33	0.50	0.20	0.60	0.75	0.40	Bad attitude
Yelling	0.22	0.25	0.20	0.10	0.25	0	Shouting
Aggressive physical contact	0	0	0	0.60	1.00	0.20	Unpleasant physical contact
Throwing things	0.11	0.25	0	0	0	0	Throwing objects

Note. The scale ranged from extremely disliked (0.00 = F) to extremely liked (4.00 = A).

a N=9. b n=5. c n=4.

p < .01

youth have been pronounced. A typical teen in the mid-1970s had a choice of two or three network TV channels, usually viewed with other family members on the only household television. They listened to music either on their AM radio or on an eight-track tape player, and they may have owned the only video game then in existence—Pong.

By contrast, today's youth typically have access to hundreds of TV channels (usually on television sets in their bedrooms), personal computers offering an infinite array of content via the Internet, VCR and DVD players and recorders offering a virtually unlimited variety of music and movies, and multiple devices on which to play a plethora of animated, interactive video games. Moreover, these media devices do not sit idle. Gentile and Walsh (2002) conducted mail surveys with telephone follow-up and found the typical youngster watches 25 hours of television weekly, plays

computer or video games 7 hours weekly, and accesses the Internet from home 36 minutes a day.

In terms of content, 1970s television shows (such as *The Brady Bunch*, *Happy Days*, and *Welcome Back Kotter*) tended to portray adults who were honorable, thoughtful, and generally positive in their dealings with both young people and other adults. By contrast, today's common family fare are competitive elimination programs, such as *Survivor* and *The Apprentice*, that tend to lionize aggressive, intimidating, manipulating, dishonest, and other untoward adult behavior. Also, the conventional themes in cinema, music, and video games have become more violent over the past several decades.

Films such as *The Matrix* and *Kill Bill* have tended, much more than earlier films, to glamorize the aggression and brutality of their heroes. Similarly, gangsta rap musicians pointedly encour-

age violence, intimidation, and drug use (for example, Eminem's "Purple Pills," 50 Cent's "High All the Time," and Snoop Dogg's "Deep Cover"). Today's youth can also actively participate in acts of violence usually associated with war and crime by taking on the role of a digitally animated adult in modern video games, including *Doom*, *Quake*, *Grand Theft Auto*, and *Halo*.

We are not trying to moralize but to point out that the world is different today, at least with respect to adult behaviors in the media. We conducted our replication of the Willner study to learn if that difference has affected the preferences youth have for the behavior of real adults in their care environments.

Summary of the Method

The original Willner study involved 11 boys and 8 girls, ages 12–16, residing in group homes that incorporated the TFM program of treatment—known then as

the Achievement Place program. A series of eight millimeter films were produced showing adults engaging in a variety of social behaviors commonly observed among child care workers in residential facilities.

Each of the 19 youth viewed the vignettes and wrote comments about the social behaviors portrayed by the adults in the films that they liked and disliked. Four independent observers, all graduate students at Kansas University, reviewed the several hundred youth comments and cast them into 33 categories with brief descriptions such as *being fair*, *helping*, *smiling*, *being rude*, *blaming*, *yelling*, and *cursing*. Finally, nine of the youth, four boys and five girls, graded each category from A to F in terms of how they preferred their adult caregivers to behave toward them.

Our 2005 replication of the 1977 study was precise. We studied 11 girls and 8 boys in residential care whose life circumstances (for example, whether they were adjudicated delinquent or undisciplined, neglected, or abused), ages, and current placement in the TFM group homes were virtually identical to the Willner participants.

In consultation with Willner and another surviving author of the original study, we created videotaped vignettes comparable to those used in the earlier

To conduct a correlational analysis between the data of the two studies, we undertook the matching of all comparable category descriptors from each study.

study (the original vignettes were recorded on eight millimeter film and have been lost). Their descriptions provided sufficient information to duplicate the intent, running time, and approximate content of the original vignettes.

As in the original study, our 19 participants viewed the vignettes and wrote comments describing why they liked or

disliked the adult behavior shown. A panel of four independent judges categorized the comments into 29 categories, though not all were the same as those in the original study.

To conduct a correlational analysis between the data of the two studies, we undertook the matching of all comparable category descriptors from each study. Two categories were considered equivalent if the descriptors resembled each other or expressed similar characteristics. For example, the categories of *being fair* and *fairness* were matched, as were those of *name calling* and *mean, insulting remarks*. Two-thirds of the adult behavior categories from the two studies could thus be matched, and the correlations between those sets of matched categories constituted the core results of the replication.

A fully detailed description of the rationales, method, and results of this study is located online at www.familyinnovations.org/Willner-replication.

Results and Discussion

The adult behavior categories thus matched, as well as the youth ratings of each category, are shown in the Table on page 8 (the A to F ratings were converted to a 4-0 numerical scale for purposes of statistical comparison). The Pearson product-moment correlations among these matched pairs of ratings were not only strong and positive, but also statistically significant ($p < .01$) between the three sets of scores from both studies. The r coefficient for all youth scores was .973, .902 for the boys' scores, and .948 for the girls' scores.

Our replication questioned if the many influences bombarding contemporary adolescents by the media-intense environment of the information age may have changed youth preferences for the behavior of adults around them since the Willner data emerged in 1977. The effects of the ever-expanding role media play in modern life, the types of adult role models routinely portrayed in the media, and the drift of content toward rewarded aggression and violence prompted our inquiry.

We conclude from the correlations that youth in care today prefer almost exactly the same adult caregiver behaviors as they did 27 years ago. Similarly, and perhaps more importantly, today's youth continue to dislike adult anti-social behavior.

We conclude from the correlations that youth in care prefer almost exactly the same adult caregiver behaviors as they did 27 years ago.

Implications

Those of us who truly care about the well-being of the children in our charge have become increasingly sensitive to the effects of the physical and emotional injuries our clients have experienced. That sensitivity has left us recoiling at the mounting evidence that the coercive control of children in care, such as physical restraint, pharmacological restraint, and seclusion, may be on the rise in many care environments.

On other fronts, evidence has begun to trickle in that such methods may be unnecessary (Masker, 2001; Jones & Timbers, 2003). If the present data offer nothing else, they suggest this important advice: If we wish to treat young people effectively, we must first—and still—treat them well.

We thank everyone who participated in filming, viewing, and rating the video vignettes for this study. We extend credit and tribute to Montrose Wolf, whose pioneering efforts in the application of behavior analysis to residential youth care will be remembered.

Send comments about this article to:

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

POINT: Using a nationally recognized behavior support and intervention training model can significantly reduce an organization's reliance on seclusion and restraint.

by Joseph K. Mullen

In 1989, the U. S. Supreme Court in *Canton vs. Harris* ruled that government organizations have an “affirmative responsibility” to train their staff to perform work duties competently. This ruling was significant because it was the first time the issue of “failure to train” was made central in litigation. As a result, service agencies throughout the country were placed on notice that “training” for staff was considered an affirmative responsibility.

The *Canton vs. Harris* ruling has had a significant effect on human service agencies by requiring them to train staff in performance areas pertinent to the service being delivered. When this effect is boiled down, it means staff must be prepared to perform tasks that may occur within the framework of their employment. For example, in residential child care, an emergency situation such as a fire in a trashcan may occur. The child care staff must therefore be trained how to properly use a fire extinguisher. Fires may be infrequent, but they have a potential for tragedy, so staff performance must be ensured.

Today, the most significant debate in human services—and particularly in youth services—is the use of seclusion and restraint. Across the field, there is agreement that these interventions are overused and must be reduced and, some believe, eliminated.

I don't agree with the latter. I'm not a fan of seclusion, but I do believe certain populations and circumstances make it a legitimate tool. Additionally, I know client behavior can occur

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COUNTERPOINT:

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

by Keith A. Bailey

Using one of the nationally recognized behavior support and intervention training programs is only one component necessary for reducing restraint and seclusion in any treatment program. The entire treatment culture must change to sustain any positive changes from such training.

Some agencies do implement a new training program for behavioral support and experience initial success in reducing restraint and seclusion. Though some of this success is due to implementing the training effectively, another factor may be attributed to the “Hawthorne Effect” of simply seeing positive change due to the increased attention to the issue of restraint and seclusion.

Such positive change, however, will not be sustained, and greater success will not be achieved, unless an ongoing culture change occurs in treatment philosophy that both compliments and supplements the training. In fact, what is taught in the training may contradict the agency's existing policies, procedures, and practices. Such contradictions cannot find a sustainable foothold in the culture of the agency, even with the best training curriculum.

Changing the culture of treatment to support the philosophy and practices promoted in training curricula is far more complex than simply ushering a new training program into the existing treatment culture. Multiple steps are involved in such a culture change. Both CWLA and the National Technical Assistance Center (NTAC) for State Mental Health Planning

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that is harmful to the client or others and that physical restraint as an emergency is necessary. Agencies have an affirmative responsibility to ensure staff members are trained to use these emergency responses.

Organizations face the paradox of reducing these interventions while ensuring staff use them competently. At first glance, this may seem like a problem plagued by contradictions, but it doesn't have to be.

Both sides of the issue can be satisfied by implementing one of the nationally recognized training models that are aligned with the *Best Practice Standards in Behavior Management* and the *Best Practice Guidelines in Behavior Support and Intervention Training* developed by CWLA.

For more than 20 years, I have been active in the development of a comprehensive training curriculum for behavior management in schools and residential care. Recently, I was privileged to take part in CWLA's national task forces that developed the *Best Practice* monographs. Although much of the *Best Practice* material was already part of our training curriculum, these standards

Organizations face the paradox of reducing these interventions while ensuring staff use them competently. At first glance, this may seem like a problem plagued by contradictions, but it doesn't have to be.

and guidelines have bolstered the program as a state-of-the-art approach. This training model has been correlated with significant decreases in seclusion and restraint. I believe the reported reductions are connected to a number of items in the training. The same reduction outcomes are likely true of other training models congruent with

the *Best Practice* approach.

The training content that makes a difference includes:

1. Mission clarification, identifying the service client as paramount.
2. Emphasis on client safety.
3. A comprehensive prevention and intervention approach based on the LRA.
4. An introspective requirement for staff on instincts for counter-aggression.
5. A mastery of nonphysical and physical skills.
6. An array of client-safe, physical intervention techniques allowing individualized client response.
7. An after-intervention debriefing for all involved.
8. An after-training follow-up connection to supervisors.
9. A requirement for data collection and analysis.

These components and other aspects of the training program make a difference. One particular concept, however, is exceptionally salient. In our experience, the concept of staff "counter aggression" has been repeatedly reported as affecting reduction outcomes. This concept requires staff introspection about their responses to their clients' everyday behaviors.

According to agencies, this part of our curriculum has significantly affected staff response to behavior and dramatically reduced emergency incidents. Reports have come from large programs, such as the Connecticut Juvenile Training School and the Los Angeles County Detention Programs, and from smaller providers, such as La-Sa-Quik, in Cogan's Station, Pennsylvania (which reported almost zero incidents over two years), and the Sequoyah Adolescent Treatment Center in Albuquerque, New Mexico (which reported an 80% reduction in incidents).

When a comprehensive training model is implemented, it stimulates examination and change in a variety of areas in the service organization. For example, several juvenile justice organizations retitled and rewrote their "use of force" policy and subsequent policy training to a "safe intervention" policy

and training.

Now, as new staff enter these organizations, their perspective on the mission is not directed by the correct use of force, but by a sense of mission that is driven by client safety.

When a comprehensive training model is implemented, it stimulates examination and change in a variety of areas in the service organization.

When a service organization implements a comprehensive training model, it turns over a rock under which many issues hide. Many of these issues lead to overusing emergency procedures. Implementing the model forces exploration and resolution of these issues.

Our clients do not develop in a perfect world, and it's unlikely we can create one for them. It's better to make an effort to respond professionally to the imperfections that exist for both clients and staff.

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have developed training curricula and publications naming several factors that should be in place to sustain success and make further progress in reducing restraint and seclusion. Essentially, these changes reshape treatment culture.

These culture change elements can be broken down into six categories:

- changing the organization through leadership involvement;
- using data to inform practice;
- developing the workforce, with an emphasis on training in trauma informed care;
- using prevention tools;
- using debriefing for both youth and staff after incidents of restraint and seclusion; and
- gaining input from youth and their families (NTAC, 2004). Though all six strategies are necessary for success, I will focus on two that are important in culture change, namely the role of leadership and workforce development.

Agency leaders must set both the tone for the culture change and concrete goals for reducing restraint and seclusion. Because such a change is quite complex, it's better to use a top-down, bottom-up approach rather than having top leadership mandate the change with no collaboration with staff. In the top-down, bottom-up approach, leaders set the tone for change and create goals to measure success, but they also provide support and resources to those making the change happen. They elicit the collaboration of all levels of staff to work out the details of how the change should happen. Using this approach, there is ownership at all levels of the agency for the culture change.

Workforce development is one of the most important factors involved in this culture change. The training should be heavily weighted toward developing deescalation skills over and above restraint and seclusion techniques. Safety issues also must be a critical component of the training. Not only should staff be trained using a nationally recognized curriculum, their success in that training should be measured through competency-based testing. Refreshers should also be offered at a minimum of

six-month intervals.

Though a behavior and support training curriculum is nationally recognized, this does not necessarily mean that it focuses on deescalation, is safety-focused, or follows best practices in the area of restraint and seclusion. An agency should scrutinize the training curriculum it adopts and ensure the curriculum follows best practice standards in the field and fits the agency's treatment philosophy.

Though a behavior and support training curriculum is nationally recognized, this does not necessarily mean that it focuses on deescalation, is safety-focused, or follows best practices in the area of restraint and seclusion.

Workforce development should also include training on trauma-informed systems of care, understanding child development, understanding behavior goals, strength-based approaches, and effective, active listening skills. Additionally, staff must receive concrete, alternative interventions to replace restraint and seclusion—you can't take away a tool without putting another in its place.

Additional training must support a nationally recognized curriculum.

Though an agency can provide the best training possible, proper, consistent supervision is necessary to provide both modeling of the techniques presented in training and accountability for the proper implementation of the training. In these ways, leadership is an important factor in ensuring that training makes a difference in the culture of treatment.

Using the right nationally recognized training program can play an important part in reducing the use of restraints and seclusion, but it's only a part of the overall equation for success. Nothing short of a culture change, with an emphasis on leadership support, accountability, and comprehensive workforce development, will sustain the change needed to offer youth in our care a more therapeutic environment.

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References

National Technical Assistance Center for State Mental Health Planning. (2004). *Training curriculum for the reduction of seclusion and restraint*. Alexandria, Virginia.

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

Question: Should prone restraints be eliminated from practice?

Point: Prone restraints have been associated with numerous deaths and injuries and should be banned from practice.

Counterpoint: Prone restraint is only one factor associated with restraint-related deaths and injuries. Not enough is known about restraint techniques to single out one technique for elimination.

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References

- Fixsen, D.L., & Blase, K.A. (2002, March). *Publications regarding the Teaching-Family Model*. Available online at <http://www.teaching-family.org/June2002bibliography.doc>.
- Gentile, D.A., & Walsh, D.A. (2002). A normative study of family media habits. *Applied Developmental Psychology, 23*, 157–178.
- Jones, R.J., & Timbers, G.T. (2002). An analysis of the restraint event and its behavioral effects on clients and staff. *Reclaiming Children and Youth: The Journal of Strength-Based Interventions, 11*, 37–41.
- Masker, A.S. (2001). Reducing physical management and time-outs: One agency's experience. *Residential Group Care Quarterly, 2*, 1–7.
- Willner, A.G., Braukman, C.J., Kirigin, K.A., Fixsen, D.L., Phillips, E.L., & Wolf, M.W. (1977). The training and validation of youth-preferred social behaviors of child-care personnel. *Journal of Applied Behavior Analysis, 10*, 219–230.
- Blackman, M., Eustace, J., & Chowdhury, M.A. (1991). Adolescent residential treatment: A one to three year follow-up. *Canadian Journal of Psychiatry, 36*, 472–479.
- Brazier, D.J. (Ed.). (1996). *Family-focused practice in out-of-home care*. Washington, DC: CWLA Press.
- Child Welfare League of America. (2004). *Standards of excellence for residential services*. Washington, DC: CWLA Press.
- Curry, J.F. (1991). Outcome research on residential treatment: Implications and suggested directions. *The American Journal of Orthopsychiatry, 61*, 348–357.
- Curtis, P.A., Alexander, G., & Lunghofer, L.A. (2001). A literature review comparing outcomes of residential group care and therapeutic foster care. *Child & Adolescent Social Work Journal, 18*, 377–192.
- Day, D.M., Pal, A., & Goldberg, K. (1994). Assessing the post-residential functioning of latency-aged conduct disordered children. *Residential Treatment for Children and Youth, 11*, 45–61.
- Hooper, S.R., Murphy, J., Devaney, A., & Hultman, T. (2000). Ecological outcomes of adolescents in a psychoeducational residential treatment facility. *American Journal of Orthopsychiatry, 70*(4), 419–500.
- Landsman, M.J., Groza, V., Tyler, M., & Malone, K. (2001). Outcomes of family-centered residential treatment. *Child Welfare, 80*, 351–379.
- Lazelere, R.E., Dinges, K., Schmidt, M. D., Spellman, D.F., Criste, T.R., & Connell, P. (2001). Outcomes of residential treatment: A study of adolescent clients of Girls and Boys Town. *Child & Youth Care Forum, 30*(3), 175–185.
- Pecora, P.J., Whittaker, J.K., Maluccio, A.N., & Barth, R.P. (2000). *Child welfare challenge*. (2nd ed.). New York: Aldine De Gruyter.
- U.S. General Accounting Office. (1994). *Residential care: Some high risk youth benefit, but more study need-*
- ed. Washington, DC: Author.
- Weiner, A., & Kupermintz, H. (2001). Facing adulthood alone: The long-term impact of family break-up and infant institutions: A longitudinal study. *British Journal of Social Work, 31*, 213–234.
- Whittaker, J. K. (2000). Reinventing residential childcare: An agenda for research and practice. *Residential Treatment for Children & Youth, 17*(3), 13–30.
- Whittaker, J.K., & Maluccio, A.N. (2002). Rethinking “child placement”: A reflective essay. *Social Service Review, 108*–132.
- Whittaker, J.K., & Pfeiffer, S.I. (1994). Research priorities for residential group child care. *Child Welfare, 73*, 583–601.

Additional resources may be found online at www.cwla.org.

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