

Chaos On The Campus: Recognizing the Early Warning Signs A Guide for Administrators of Residential Centers

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Abstract

As more children enter the child welfare system with serious emotional and behavioral problems of a type that many foster parents feel unprepared to address, residential treatment centers are often a better option for children who would otherwise experience multiple placement disruptions and who may not receive the care they need in less restrictive settings. The author uses twenty-five years of personal experience managing residential treatment programs to help the reader discern the differences between well-run programs and those on the verge of chaotic disruption. He reviews the literature on residential campus breakdown, identifies crucial elements of well-run therapeutic residential programs, and provides clues to recognize early warning signs of impending crises. While he eschews the notion of "best practice" in residential treatment, he nevertheless identifies for the reader common organizational structures and procedures of programs that are well managed and that successfully meet the particular needs of the many children they serve.

Introduction

Residential treatment centers are complex, dynamic, interactive environments that must be carefully designed to meet the specific needs of the troubled youth placed in their care. "Residential facilities purposefully integrate various program activities into the stream of each child's daily living experience. All program elements, ranging from recreation to one-to-one treatment and from routines of daily living to group therapy must be interrelated to create an overall positive impact on the child during his stay in residence" (Weber & Haberlein, 1972).

In addition to carefully designed programs and treatment plans, the effectiveness of residential care hinges on forming and maintaining constructive relationships at every level (staff and children, staff and staff, children and children, and with program administrators). Accordingly, simplistic platitudes and rigid adherence to any one "best way" of doing things for every situation or every child are bound to undercut the complexity of informed judgments necessary

to create and sustain the therapeutic milieu that minimizes acting out behavior by both staff and clients. All too often, attempts to oversimplify the complexity of residential care result in the kind of chaos frequently featured on the front pages of newspapers in major cities throughout the United States. Chaos on residential campuses occurs even though there are well-known practices and procedures for effective management of Residential Treatment Centers. This paper will review studies of campus chaos, identify the crucial elements of well-run therapeutic residential settings, and provide ways for management to recognize the early signs of impending crises. In addition to culling data derived from a review of the relevant literature, I am drawing from guidelines I developed when I was director of a well known 75-bed residential treatment center. I apply these principles when evaluating agencies in my role as an accreditation peer reviewer. In my role as Executive Director, with greatly reduced access to clients, I found that these same tools worked at long range.

The Problem

It's everywhere, it's everywhere, or is it?

Given the hyperbole and selective information available through the media when a campus is in chaos, it is easy to conclude that a residential center in crisis is a horrible, unfriendly environment. Or, conversely, because of the status or political standing of the residential setting in the community, it may be said that if this outstanding place is so bad, others must be worse and that this must be a terrible form of treatment. Nothing could be further from the truth. Most residential treatment centers do a reasonable job. The national data suggest most children benefit from residential treatment. Those campuses that lose control have failed to implement and maintain the necessary organizational and milieu treatment methods. To further inform the heated debate in our state, we can look elsewhere to understand how a campus loses control of its clients, environment and staff.

Berridge and Brodie (1996) reviewed a series of crises (physical and sexual abuse of clients, out of control youth, excessive runaways, etc.) at residential

treatment centers in England and Wales. They concluded these crises in care were “undoubtedly associated with ...unresolved obstacles in the management, role, status, and skills base of residential childcare.” In most professions, such as law and medicine, persons dealing with the most difficult problems are the best trained and highest skilled professionals. Yet, as Berridge and Brodie (1996) point out, in residential care too often social work staff with the least education and training are trying to help the young people with the most profound problems. Chaotic settings commonly are characterized by a loss of morale, alienation and pervasive helplessness among staff, and a lack of constructive structure which together overwhelm the residential treatment system’s capacity to respond therapeutically to client problems (Berridge & Brodie, 1996). These findings are eerily identical to the comments of staff at an Illinois campus recently in chaos (Davidson, 2002):

- “...a sense of helplessness and hopelessness pervades the staff at..., and they stop recognizing serious client behaviors when they see them. Very difficult and extreme behaviors are tolerated, and interventions such as SASS (screening) are not used or even thought of sometimes.”
- “...clinical decisions are constantly being over ridden. SASS calls are questioned and placement recommendations are blocked. DCFS Hotline calls are no longer being questioned but were in the past, and there remains a reluctance among the staff to make them for fear of reprisals.”
- “...a chain of command that ends in non-clinicians making clinical decisions is unethical.”
- “...boys threatening each other, assaulting staff and starting fires.”
- “...sense of futility in staff” about the ineffectual treatment that the program offered.

Ya’ gotta know the territory

How does the dysfunctional campus in chaos look? What is happening? What isn’t happening that should? The United Kingdom studies noted above identified common themes on chaotic campuses:

- **Management:** Inadequate line management; little direct management control with children and staff; unsatisfactory or no complaint/grievance process.
- **Policy:** No clear objectives; unsatisfactory placement policy and processes; unsatisfactory recruitment processes; inadequate staff training; reluctance to use secure provisions; desire to

contain own problems; social isolation of unit.

- **Practice:** Macho/masculine charisma or culture; inappropriate practice/treatment methods; adults unwilling to believe children; financial problems; physical shortcomings of units; insufficient staffing; inadequate or no specialist external professional advice.

So much information, so little knowledge

What is often startling to this observer is how each campus crisis appears to be a de novo experience, and how little we learn from the experiences of others, or from our field’s literature on best practices. Obholzer (1995) confirms the complexities of residential care and gives a reason for this lack of learning. He recognizes the unique and serious risks in working with disturbed adolescents in residential settings. He goes on to say that workers in the field know the risks quite well, but surprisingly little is written about these problems because it is almost impossible to disguise the extant treatment centers when writing about institutional problems.

Whether denial, cover up, respect for colleagues or client confidentiality is at the root of our inability to study chaos on the campus, Oberholzer’s comments, and what we see each time a residential setting “makes the news” resonate with Durkin’s (1982) observations about institutional child sexual abuse: “Institutions’ responses to such external attack may include reactions similar to those manifested in families identified or accused of abuse: denial, cover up action, or defensive behavior. The motivations for ‘avoiding’ the problems are also similar. The accused will fear punishment or reprisal, want to protect reputations and careers, try to cover the deed to serve the long-term needs of the social unit, and be unwilling to acknowledge the presence of internal factors that lead to child abuse. Whatever the powerful forces that evoke abusive behavior, professional training and understanding do not assure the prompt, positive, and appropriate action.”

Tyranny of “Truth”

A central problem underlying inadequacies in residential care occurs when staff underestimate the complexity that goes into effectively applying a good treatment theory. Theories of how to conduct effective residential treatment abound. Clearly some theories are better than others, and as the models are tried and evaluated, some clearly are inadequate to the task. However, having a good theoretical model does not guarantee that one can apply it effectively to

the highly complex and individualized therapeutic processes that need to occur in effective residential care. Cognitive, Behavioral, Medical, Peer Culture, Psychodynamic, Re-Ed, Rehabilitation, Systems, Therapeutic Community, Teaching Family, and Wilderness Challenge are among program models that are rich and varied. All programs have varying degrees of success; all programs have various limitations. **There is no single best model of residential treatment.** We must beware of tendencies to prescribe the 'best way' to treat youth in care. We must be hypervigilant when we hear program directors say there should be no individual behavior plans in a wilderness program, no psychotropic medications in a teaching family program, or no individual therapy in a therapeutic community. These are all signals that the residential system is too rigid to adjust to the wide ranging and constantly changing needs of seriously disturbed children and youth placed in residence.

Preventing Chaos

While there is no one best model of residential treatment, effective treatment centers do have many common organizational structures and procedures specifically developed to meet the needs of the clients they serve. Adolescents come into residential care when they cannot be contained in the community, or when they need the specialized therapeutic benefits of a residential treatment center. Consequently, residential directors not only decide upon the treatment and the program, they must also ensure the best possible program implementation. If not, rather than functioning as a therapeutic containment environment, the residential center will fuel the acting-out process and lead to chaos. Oberholzer (1995) enumerates the critical elements of a therapeutic containment environment:

- clarity of task for staff and patients alike,
- clarity of structure, of authority, of roles, of boundaries,
- adequate staff training, particularly in the field of group and institutional process,
- awareness of the risks to staff, to patients, and to the institution arising from the nature of the work in which they are engaged.

“Don't put poison in their food”

Fritz Redl, arguably the wisest residential professional ever, demanded that residential treatment personnel must first and foremost care deeply about the children they serve and be tireless advocates for their well-being. They must ensure decent, benign, and non-punitive care.

“But you still have to feed them”

“Feeding them,” Redl tells us, requires knowing what to do and then doing it in order to create a healthy 24-hour a day environment that discourages pathology. Doing otherwise will create an unhealthy environment that elicits pathology (Rabinovitch, 1991).

When you need a screwdriver a hammer won't do

Your treatment model, program, treatment plans, physical plant, staff development program, and clinical capacity must be contoured to meet the needs of your client population. They all can be viewed as a box of tools, and like a box of tools, must be constantly reviewed and updated to meet the demands of the job at hand.

As the number of children referred for residential services decline, those youngsters coming into care appear to come from more dysfunctional family and community systems, and as a result they manifest more symptoms, and more intensive pathology. Moreover, there is reason to believe that most of the children who are still in the care of the public child welfare systems by the time they reach adolescence have difficulties for which the previous service models were inadequate. Too often, succumbing to financial pressures, residential programs admit these more difficult youth without reformulating their programs to meet the higher level of care required. The clinical capacity to manage and treat these children is often non-existent.

Clinical capacity consists of essential factors such as therapist-client ratios and direct-care staffing levels adequate to meet the needs of the residents. The milieu as described above must be able to contain the residents. The direct staff must be capable of managing aggressive behavior of residents and be able to de-escalate conflicts. The center must have clinical expertise in managing depressed and suicidal clients. It must have adequate psychiatric services to help manage the care of overtly mentally ill children and to manage psychotropic medication.

The worst time is between

A residential center must have a carefully structured, 24-hour a day program. Lots of unstructured time plus large numbers of disturbed children equals an open invitation to bedlam. One campus recently in chaos had no after school program; scores of residents were on their own from the end of school

until dinner, creating a veritable breeding ground for all sorts of acting-out behavior.

There must be a protocol for what to do after children have gone to bed. A night worker once called my assistant director of residential treatment to tell him there was a car parked behind the cottage, and it looked like the driver was selling drugs to our children. The worker was advised to get the license number of the car, to call the police, and to get the children inside immediately. The basic problem was our system, that we had no night protocol. Over time we developed a night supervisor role, hired a night time security guard, and developed a protocol for how to manage various night time problems. Nocturnal events were then routinely examined in treatment team meetings, and regularly addressed in the childcare worker training program.

What does it look like when things go well?

How does the well-run campus look? Obviously, there is an absence of aggressive behavior toward residents and staff; little or no property damage; few conflicts between staff in the management clients; and little sense of pressure due to youngsters testing the limits. Patient/staff boundaries are clear, and youngsters are not demanding intense parental control. The client-staff ratio is appropriate. Staff and youth enjoy working together; the staff like the children and the children appreciate the staff. Lines of authority are clear. Communication is effective, clear and regularly occurring. Staff members feel respected by their administrators. They meet daily and feel free to express their concerns and feelings, and are supported by their teammates. There is a rich and varied array of activities that absorb youngsters' energy. Problems that occur are recognized and addressed by the staff, who do not feel they have to deny the problems or hide them from administrators. Program and treatment plans are implemented as prescribed.

Recognizing the Warning Signs

How can the agency executive staff recognize developing crises when they do not have day-to-day contact with the residents and direct care staff? Here are some useful tools garnered from over 25 years of experience managing outstanding residential treatment programs.

The rule of three kids

If the reader comes away with a full understanding of this principle and how to apply it, he or she will have gained the single most important tool for recognizing the warning signs of impending campus

chaos. Simply stated the rule of three kids is:

1. If one child in a living unit is acting out, it is probably related to the child's psychopathology (although we must remain vigilant to the possibility that the child is either being scapegoated or acting out for the group).
2. If two children in a living unit are acting out, it may be due to the children's psychopathology, but it may also be a program, treatment plan, or staff intervention problem.
3. If three children in a living unit are acting out, it is absolutely due to the environment, i.e., the program, the treatment plan, and the staff interventions.

Opportunities to apply the Rule of Three Kids arise regularly in residential treatment centers:

- **Excessive runaways** A group home for 14- to 18-year-old adolescent girls was experiencing almost daily runaways. Most were overnight short-term runs. The analysis of the runs included both antecedent and post-run events. A very careful, caring and worried staff spent one to two hours in private with each young woman when she returned from the run. The girls loved the private time with the staff, who were inadvertently reinforcing the runaway behavior by concentrating their intense attention to the girls primarily on times when the girls had run away.

I directed the staff to determine whether the returning youngster needed medical attention and then to return the girl to her program immediately, without conversation about the run, and to assign the task of examining the run to her therapist. The staff were instructed to find regular time every week for lengthy private conversations with their clients, and to find time whenever possible to reinforce positive behavior. The runaways ended immediately.

- **Excessive medication** In one unit of a residential treatment center, 14 of 22 adolescent males were on psychotropic medication. This was almost the total number of children medicated on the entire campus. I told the physician, "Mel, I cannot question you about any individual decision you make regarding medication, but I can question the overall large number of psychotropic prescriptions." The physician immediately told me that the unit leadership was horrible, the staff incompetent, and that he was trying to keep the children safe by slowing them down and medically over-

whelming their aggressive inclinations. A quick review of the program included meetings with the unit director, cottage directors, child-care and social work staff and confirmed the physician's observations. We discovered that the unit director actually was telling the residents that when they were angry, they should break things such as the cottage windows, or throw things out the window. He was immediately fired, and the staff was given intensive behavior management and de-escalation training. The vandalism and interpersonal aggression diminished greatly, and all but 3 of the youngsters were withdrawn from psychotropic medication.

- **Bedlam on the unit** A locked, intensive care unit was experiencing nightly near-riot behavior by several of the residents. Every night I would dutifully come to help restore order. Of course, my interventions further undercut the staff's authority and fueled even greater acting out. Bringing together a team of our top program staff, we reviewed the unit's program. There was no program, and no basic structure. The youngsters essentially "hung out" after school until they went to bed. I replaced the director with my top unit administrator. He literally moved in and did a complete remake of the unit. Starting with involving all the children in the selection of new furnishings and wall hangings, he went on to develop a comprehensive, 24-hour highly structured program plan with clear role expectations for the staff and residents, thereby creating an effective therapeutic milieu. End of nighttime madness.
- **Anger and fear on the unit** Every morning one or more residents of an 8-bed closed psychiatric residential unit acted out aggressively against peers, staff or property. Different youngsters were involved on different days. The residents were constantly verbally abusive to the day staff. Their verbal attacks were vicious, e.g. they told other children and staff that the scars on the arms of one of the most effective staff members, who was a blood donor, were "shooting" sites from heroin use. Overall the residents sounded frightened by and angry with the staff, as if staff were failing to protect them. We realized that there must be something scary going on at night. The unit director and I alternated late night and early morning surprise visits to the unit. We consulted with the night watchman and

the night supervisor. We decided that the night staff were either sleeping on the job or leaving the unit unsupervised. We could find no evidence to support either supposition. The acting out continued. We asked the therapists to raise the issue in their therapy sessions with the residents of the unit. After two more weeks the clients told the therapists that one night staff member was sleeping with at least two of the girls and physically abusing a third.

We immediately informed the therapists of all the children in the unit. We suspended the staff member and upon investigation fired him, filed an abuse report and worked with the District Attorney's office to prosecute him. Managing a campus when there are allegations of child sexual abuse is a complex issue beyond the scope of this article but addressed elsewhere by this author (Bloom, 1992).

Show me the money

In his wonderful workshop for new child welfare executives, Child Welfare League of America Executive Director David Liederman, of blessed memory, used to admonish new executives to "follow the money" and to sign every check for at least two years. In this manner, he reasoned, they would come to understand the complexity of their organization and how resources were being utilized. The monthly P and L statement is not only an excellent tool for managing the residential center's expenditures and reviewing its revenues, but, in addition, a careful review of specific line items can be a powerful tool to spot impending crises.

- **Personal items** This typically includes items like haircuts, tooth-brushes and toothpaste, deodorant, perfume, feminine napkins, and the like. When the expenditure of these items falls well below the budgeted amount, something is disrupting the basic program of the unit and it is a wake up call for the executive staff to look into the situation.
- **Allowances** As with personal item expenditures, underutilization of the allowance budget suggests residents are being punished. This, too, requires immediate review by the executive staff.
- **Recreational programming** Underspent recreational funds can be an even more serious bellwether of impending chaos.

Many residential treatment centers have a carefully developed therapeutic recreation program to match the needs of the residents. Therefore, when recreational expenditure is well under budget, treatment plans are not being followed. This can reflect a very serious problem and also requires immediate review by the executive staff. A cottage for 12 pre-adolescent boys was not spending their recreational funds, even though cottage staff were acknowledged to be the best milieu programmers on campus. They had well-developed therapeutic recreation and camping programs. When questioned about this, the cottage supervisor replied, "How can we go to camp when I can't get the children out of the walls?" It was a time when the treatment of sexually abused boys was in its infancy. Misinformed by a theoretical model in its infancy, we made an incredibly bad decision to place 10 sexually abused boys in one cottage, and to have them in a sexual abuse therapy group. This resulted in overwhelming emotional "heat" in the cottage. The boys were literally punching holes in the walls and climbing into them to escape; they also were hiding in the rafters. The program had come to a total stop as the staff was enmeshed in constant crisis management. We were not yet regularly including vandalism on our incident reports, thus financial data was the only indicator that the program was in serious trouble.

It is important to note that not only are there programmatic and treatment plan implementation failures, during a crisis paper work is not completed either. Although the absence of paperwork signals a problem, the only window for seeing the source of the problem may be through financial reports.

- **Personnel** When personnel costs far exceed the budget, one of two things is most likely occurring. Either there is excessive absenteeism, or there is a great deal of turnover. Both require immediate executive review. Higher costs result when staff work overtime to ensure proper coverage. Over time, this can become quite burdensome on the direct service staff, and may lead to failures in treatment planning and programmatic follow-through.

Measure twice then measure again

Executive staff need a constant stream of data to assess the health of their program. Comprehensive Quality Assurance and Utilization Review systems

must be in place. Frequent peer reviewers identify the absence or inadequacy of the organization's Continuous Quality Review policies and procedures as the single greatest failing that delays agency accreditation. These policies and procedures are key to the early identification of impending chaos.

- **Utilization review** Do the clients match the program, or conversely, are the program elements able to meet the needs of the seriously disturbed children in care? Do the diagnoses match the history and presenting symptoms? Do the treatment plans follow logically from the diagnosis, history and presenting problems? Do the prescribed interventions actually occur? Are there deviations from behavior management and de-escalation policies and procedures? (This, of course, presupposes such plans are in place.) Failures along these dimensions indicate that the program will not be able to contain the residents, nor provide a therapeutic environment.
- **Outcome studies** What is happening to the clients in your care? Are they getting better? How do you know? After reviewing the outpatient records of many agencies, I concluded that it was almost impossible to determine from their records whether clients were getting better or worse. The critical question we must all ask is, "How will the client look when he or she improves?" The record must reflect progress toward that goal, and such data needs to be aggregated so that the executive staff and board can determine the program's overall effectiveness.
- **Incident reports** Incident reports should be generated for any untoward event such as illness, injury, timeout, seclusion, restraint, fights, assaults on staff, runaways, and any physical encounter between staff and clients. All such reports must be reviewed by the executive staff. The data should be aggregated in order to develop baselines for each type of event. Spikes from the baselines need to be examined (but don't forget the Rule of Three Kids). In addition, the aggregated data must be analyzed by type of event, residential unit, child involved, and the staff member, thereby helping to focus more sharply on the problem. The results should be reported regularly to the board.

When consulting with one organization that wanted to develop a behavior management-training program for their direct line staff, I asked to see their incident data in order to develop a

program specific to their needs. One staff member accounted for over 70% of the events! This particular organization saw the locus of problems as always within the children. Therefore, when I suggested that an experienced senior member of the staff was causing or at the very least escalating minor behavioral incidents into serious problems, I angered the executive staff and had my contract terminated.

Participating in a peer review of another organization, I was given a year's worth of data prepared by the Director of Quality Assurance. There were an excessive number of severe incidents, including over 150 assaults on staff by residents. In this situation, the problem originated in the denial of the agency's executive director, who maintained, on the basis of some clinical rationale that was never clearly stated, that the reports were irrelevant. The executive director told me to ignore these reports "because the QA director was not a clinician." He then told the QA director that by giving me those reports he demonstrated that he "didn't understand the program," and, after all, this "wasn't a medical model institution." A few weeks later the state removed all the youngsters from the campus.

- **Psychotropic medications** The use of psychotropic medications must be regularly reviewed, since high utilization of psychotropic medication can often be an indicator of an inadequate milieu, inadequate program, improper treatment plan, or follow through failures in each of these areas. At a group home for 12 seriously disturbed adolescent girls, all were on at least 2 psychotropic medications. Upon investigation, all of the girls came into residence from psychiatric hospitals with orders for multiple psychotropic medications. Our staff psychiatrist was actually reducing the amount of medication. (Sometimes vigilance is rewarded with pleasant surprises.) This example also indicates that when residential treatment is working, the children will settle in and feel secure. Although this process takes a while (and varies for each child), the children's symptoms should improve so that they will not continue to need the same level of medication they needed to manage the upsurges of anguish they experienced in the crises that brought them to inpatient units.

When stars collide capture the stardust

Effective residential treatment centers establish true multi-disciplinary teams. Each professional group –

psychiatrists, psychologists, childcare workers, social workers, and teachers – must participate. The concerns of one group cannot be simply overruled by any other group. Everybody must be heard. Frequently, teachers know a great deal about the state of the campus program, often spotting problems no one else will raise for discussion. Conversely, direct line staff often know who the weak teachers are; and, therapists typically know which residential units are not following through on treatment plans.

A two-cottage residential treatment unit of 24 boys was at constant odds with the director of our drug abuse program. Even though he was an experienced licensed clinical social worker, as well as a certified drug and alcohol abuse therapist with years of experience integrating both disciplines, the direct staff, unit directors, and even unit social workers constantly criticized him. They claimed he really didn't understand milieu treatment. The director claimed that the staff was undermining his prevention and treatment work with the residents. When I looked into this conflict, I discovered that 4 childcare workers and two cottage supervisors had severe drug and alcohol problems of their own, and were indeed sabotaging the drug treatment program.

Listen to the children

While sometimes distorted, children's perceptions and complaints about the staff are usually based on reality. In a major crisis at a well-known treatment center for young children, one 7-year-old boy told his therapist that his primary child care worker had been having sex with him. For the previous two years the worker had been given an award as the top child care worker in the agency. The therapist interpreted the child's disclosure as fantasy. The child told several other staff, all of whom reported it back to the treatment team and the director of the agency. In every case it continued to be ignored and defined as fantasy or worse. The boy finally told his mother, who contacted the county child abuse hot line. The county investigated immediately and ended up removing all the children from the residential program. The "worker of the year," it seems, was having sex with several young boys on various camping trips. Simply considering that the child could be telling the truth would have kept this agency off the front pages of the local newspapers, preserved the Executive's job, prevented the program's closure, and kept the staff from the morass that has continued to haunt the agency even years later.

Last Words

At one time or another most residential treatment programs will have to cope with seriously dysfunctional client or staff behavior. What this paper addresses, however, is chronic, systemic dysfunction built up over a period of time. This paper also offers strategies to help residential administrators identify difficult situations and prevent them from escalating into chaos. Residential treatment administrators should identify and employ other indicators that they have found useful. Ideally, they should demand the

data needed for frequent checks of the program's health. Reviewing the sorts of data suggested here allows anticipation of problems and suggests interventions to restore campus equilibrium promptly. Being prepared to avoid chaos on the campus will help everyone sleep better at night, will greatly enrich the lives of staff, and will provide many traumatized children the best home they have ever known.

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