

# Children And Residential Experiences:

Creating  
Conditions for  
Change

INFORMATION  
BULLETIN



RESIDENTIAL CHILD CARE PROJECT, CORNELL UNIVERSITY



**Children  
And  
Residential  
Experiences:  
Creating Conditions for Change**  
Edition 7

*Information Bulletin*

**The Residential Child Care Project**

*Bronfenbrenner Center for Translational Research*

*College of Human Ecology*

*Cornell University, Ithaca, NY USA*

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Hello,

Thank you for your interest in CARE. CARE is a program model that we developed to assist child and family service agencies in improving outcomes for the children in their care. CARE is listed on the California Evidence Based Clearinghouse (CEBC) as of 2017 with a Scientific Rating of 3 (Promising Research Evidence) and a High Child Welfare System Relevance Rating (<http://www.cebc4cw.org/program/children-and-residential-experiences-care/detailed>). This bulletin provides a description of the CARE model, including our theory of change. Also included is an overview of our implementation strategy, process for data collection, a sample of a CARE proposal, as well as information on sustainability.

Our experience over the last few years has been that the implementation support we give to agencies is as important as the efficacy of the model. Our implementation strategy is an on-site model working with the organization(s) since the organization is the unit of change. We travel to deliver training and technical assistance to the organization 3 times a year for a 3-year period to assist them in fully implementing the model. Our implementation package for the CARE model is a 3-year contract. This agreement includes training, on-site technical assistance and evaluation services.

The cost for implementation is in part dependent on the size of your organization and includes all of our travel expenses and materials. In 2020 the cost of the CARE Implementation Project is \$130,000-\$178,000 (US) to be paid in quarterly payments over the three-year or four-year period. If your organization does not have an effective crisis prevention and management system in place, a combination Therapeutic Crisis Intervention (TCI) and CARE implementation project can be developed. If your organization has previously implemented TCI we may provide a TCI fidelity assessment prior to CARE implementation. For countries outside of the US, costs will vary for both the CARE and CARE/TCI implementation projects. A list of current costs is available by request.

This bulletin includes a sample proposal/scope of work for the implementation agreement. If you have several organizations interested in adopting CARE, we can discuss a system-wide implementation and evaluation proposal.

Let me know if you have any questions or would like additional information or if you would like to speak to other organizations that have implemented the model.

Sincerely,

Martha J. Holden  
Project Director  
Residential Child Care Project  
Cornell University/BCTR  
35 Thornwood Drive  
Ithaca, NY 14850  
mjh19@cornell.edu  
RCCP Web site: <http://rccp.cornell.edu>

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If you are interested in having more in-depth knowledge about the CARE model, our book, *Children and Residential Experiences (CARE): Creating Conditions for Change*, is available from the Child Welfare League of America:

<http://www.cwla.org/pubs/>

It is also available through RCCP. Please contact Trudy Radcliffe at [tr55@cornell.edu](mailto:tr55@cornell.edu).

This book describes the CARE model and is required reading for agency staff when we contract with an organization to implement CARE.

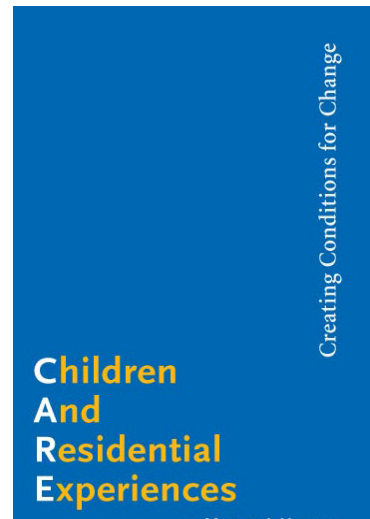
Other materials of reference include:

Holden, M. J., & Sellers, D.E. (2019). An evidence-based program model for facilitating therapeutic responses to pain-based behavior in residential care. *International Journal of Child, Youth and Family Studies*, 10(2-3):6 63-80.

Holden, M. J., Izzo, C., Nunno, M., Smith, E. G., Endres, T., Holden, J. C., et al. (2010). Children and residential experiences: A comprehensive strategy for implementing a research-informed program model for residential care. *Child Welfare*, 89(2), 131-149.

Nunno, M.A., Smith, E.G, Martin, W.R. & Butcher, S.T. (2017). Benefits of Embedding Research into Practice: An Agency-University Collaboration. Washington D.C.: *Child Welfare*, 94 (3), 113-133.

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## CONTENTS OF THIS BULLETIN

The CARE Program Model	4
Origin of the CARE Program Model	8
Implementing CARE at Your Agency	11
CARE SAmpLe Proposal	12
Bibliography	17
CARE Faculty, Instructors, and Staff	20

# The CARE Program Model

**Children And Residential Experiences: Creating Conditions for Change (CARE)** is a comprehensive program model for improving services for children in out-of-home care (Holden, 2009). This model enables child caring agencies to organize and deliver quality care of children according to research informed principles based on the best interest of the child. The CARE program model reflects the following six practice principles.

**Relationship based.** Children need to establish healthy attachments and trusting, personally meaningful relationships with the adults who care for them. These relationships are essential for increased social and emotional competence. Healthy child-adult developmental relationships help children develop social competencies that can be applied to other relationships. A child's ability to form relationships and positive attachments is an essential personal strength and a manifestation of resiliency associated with healthy development and life success.

**Developmentally focused.** All children have the same basic requirements for growth and development. Activities offered to children need to be appropriate to each child's developmental level and designed to provide them with successful experiences on tasks that they perceive as challenging, whether in the realm of intellectual, motor, emotional, or social functioning. Research and theory have shown that activities that are developmentally appropriate help to build children's self-efficacy and improve their overall self-concept.

**Family involved.** Contact with family is one of the few indicators of successful treatment that has empirical validation. Children benefit when their families work in partnership with the child caring organization. Retaining chil-

dren's connections to family, culture, and community bolsters their resiliency and improves their self-concept.

**Trauma informed.** A large percentage of children in care have a history of violence, abuse, and neglect resulting in debilitating effects on their growth and development. Adults need to respond sensitively and refrain from reacting coercively when children exhibit challenging behavior rooted in trauma and pain. Trauma sensitive responses help children regulate their emotions and maintain positive adult-child relationships.

**Competence centered.** Competence is the combination of skills, knowledge, and attitudes that each child needs to effectively negotiate developmental tasks and the challenges of everyday life. It is a primary responsibility of caregivers and the organization to help children become competent in managing their environment as well as to motivate them to cope with challenges and master new skills. Learning problem-solving, critical thinking skills, emotional regulation skills, and developing flexibility and insight are all essential competencies that allow children to achieve personal goals and increase their motivation for new learning. All interactions and activities should be purposeful and goal oriented with the aim of building these competencies and life skills.

**Ecologically oriented.** Children engage in dynamic transactions with their environment as they grow and develop. To optimize growth and development, children must live within an environment that is engaging and supportive. Caregivers must understand that their relationships with the children are part of a larger social-ecology; their face-to-face interactions with children, the activities they promote, and the physical environment in which they live

all have an impact on the developmental trajectories of children. Competent adults using skill sets informed by the CARE principles can only be effective when they are working in an ecology of care that will allow them to use their skills.

### **Relationship Between the CARE Principles and a Congruent System of Care**

Congruence based on a set of common principles that address the child's best interests is an essential ingredient in effective and high-quality residential care (Anglin, 2002). Within an organization, caregivers, support staff, and administrators must be congruent in their application of core principles that advance the best interests of children. If staff at all levels of an organization make decisions based on CARE's common principles and if they apply these principles congruently, then the experiences of staff, children and families are likely to be more positive and associated with improved outcomes. CARE lends itself to such congruence since its principles apply to various levels of an organization's structures and processes and to all of its units of service delivery such as foster family care, group living, residential treatment, and other educational and therapeutic settings. External to the organization, adherence to CARE principles by placement and regulatory agencies will increase congruence since it unifies child assessments and service decisions, requires service in the child's best interests, and expects positive child outcomes.

### **Implementing the CARE Program Model**

The CARE program model incorporates research-informed findings from the social sci-

ences literature, specifically from the fields of developmental psychology, residential care and treatment, social work, youth development, clinical psychology, and organizational development. The model is implemented through research-informed strategies such as organizational and personal self assessment, active and targeted data analysis, and training and technical assistance. Research has identified several aspects of organizational climate (e.g., fairness, role clarity, cooperation) that promote effective, innovative, and high-quality service, and ultimately result in positive child outcomes (Glisson & Hemmelgarn, 1998). Thus, the CARE implementation strategies work to facilitate activities and mechanisms that improve the organizational climate at all levels of the agency. Active data collection and analysis is continually fed back to agencies throughout implementation in order to further promote service quality and to improve child outcomes.

### **Evaluating the CARE Program Model**

The CARE program model takes a comprehensive strategy to advance evidence-based practice in out-of-home care. There are three avenues through which the evidence can inform practice:

- a. Developing practices guided by a sound theory of change (See Figure 1 on page 7) that reflects state-of-the-art research on factors that facilitate healthy child development and promote healing,
- b. Studying the CARE model with a rigorous evaluation that allows for sound conclusions about its impact on children's well-being, and
- c. Systematically reporting evaluation find-

ings back to practitioners and administrators to guide program improvement efforts and refinements to the theory of change.

In the states of North and South Carolina (US) a specially funded research project, supported by both The Duke Endowment and Cornell University, used a quasi-experimental design comparing seven agencies implementing CARE to seven matched non-implementing agencies. Cornell collected data on implementation, organizational functioning, and staff and child outcomes. This study offered an opportunity to conduct a robust evaluation of the CARE model that may have implications for residential care nationally and internationally, as well as to qualify the model as an evidence-based program for residential child care (Izzo, Smith, Holden, Norton, Nunno, & Sellers, 2016; Nunno, Smith, Martin Butcher, 2017).

### **Data Collection**

Baseline data collection for all CARE agencies includes an agency-wide survey containing the University of Tennessee's Organizational Social Context survey (organizational culture and climate), staff knowledge and beliefs, staff current practice, and youth perception surveys. These surveys and instruments are administered and re-administered, analyzed and discussed with the organization at different intervals throughout implementation to assist in decision-making and allocation of resources to the project and to measure effects.

The agencies' internal data (e.g., incident reports, intake and discharge data, staff turnover, student academic and psychometric testing) are also analyzed and considered throughout the project to help guide implementation efforts, reinforce data informed decision-making, and measure child outcomes.

### **Notes**



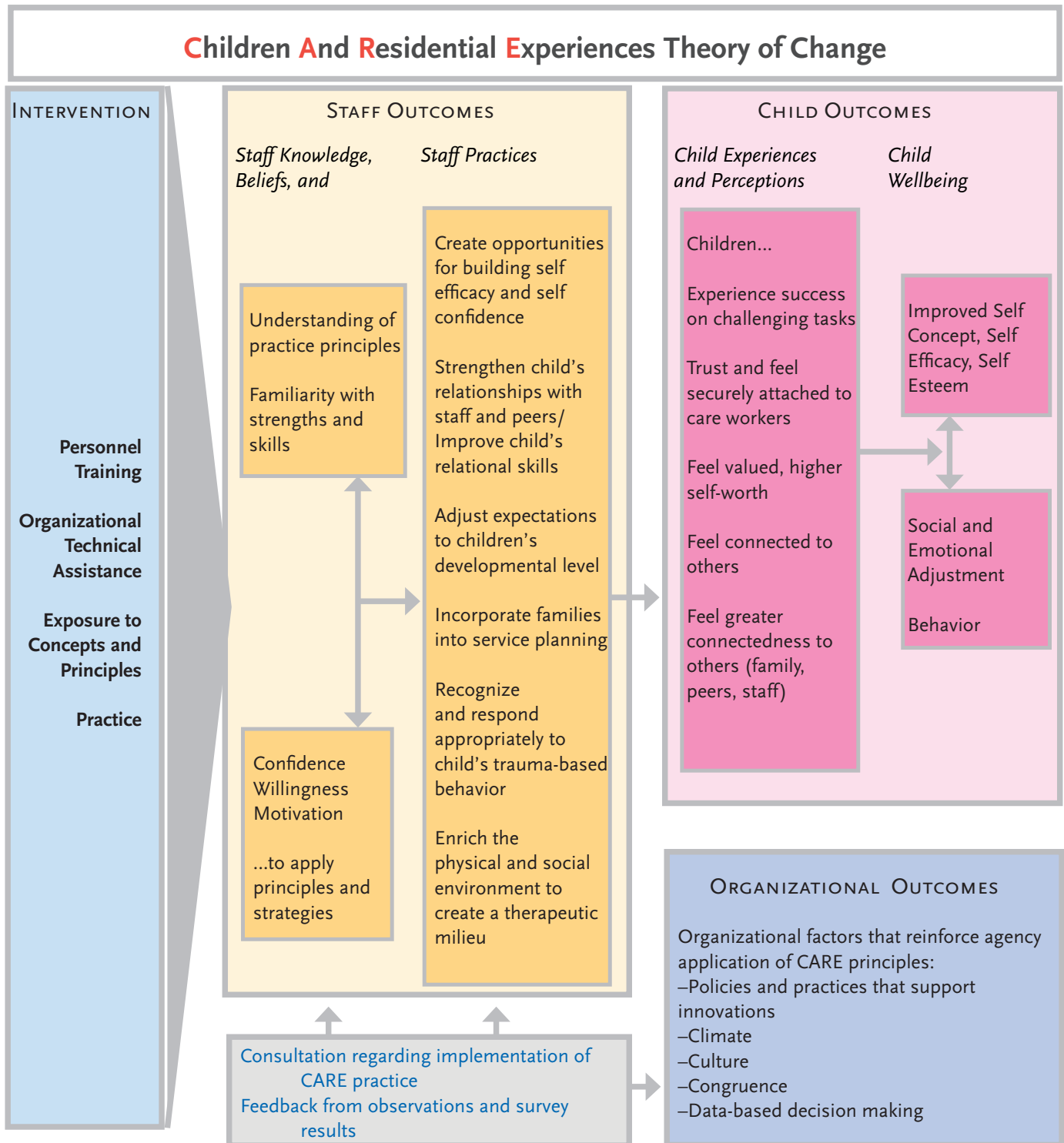


Figure 1. CARE Theory of Change

# Origins of the CARE Program Model

## Background and Research

In 2005, the South Carolina Association of Children's Homes and Family Services reviewed the training needs of South Carolina residential care staff. The Association sought a training model built on best practices for direct care staff that would support and reinforce strong programmatic elements common to a variety of residential care treatment models.

As a result of the training needs assessment, the Association considered ways to have a model curriculum designed specifically for its South Carolina member agencies and approached the RCCP. The Association requested that Cornell University's RCCP develop a competency-based curriculum based on best practices and current research to support strong programmatic elements in residential care.

James P. Anglin, Ph.D., a professor at the School of Child and Youth Care at the University of Victoria in British Columbia, Canada, undertook a multi-year study and developed a theoretical framework for understanding group care that can be used as an organizing framework for staff competencies necessary for good residential group care. Based on this theoretical framework, education and training needs have been identified for the various levels of staff involved in providing residential services. These competencies are also reflected in the North America Association for Child and Youth Care Practice competencies (2001), the United Kingdom Quality Assurance Agency for Higher Education (2000), and the British National Occupational Standards for Children's Homes.

During 2005 an international group of experts, including Dr. Anglin, convened by Cornell selected 80 key competencies from researched

and published national and international child care worker competencies (United Kingdom Quality Assurance Agency for Higher Education, 2000; North American Association for Child and Youth Care Practice, 2001; Anglin, 2002; Scottish Social Services Council, 2004). Over 100 South Carolina residential child care personnel including supervisors, clinicians, and managers verified the importance of the selected competencies to their work. After two years of research, curriculum development and training activity testing, field testing the curriculum, as well as piloting specific training implementation and evaluation strategies it became apparent to Cornell and the field test agencies, that what had been developed was more than a training curriculum, but a best practice model for working with children in out-of-home care. In 2007, the model was ready to pilot. In South Carolina pilot agencies for implementation included Miracle Hill Ministries, Inc., Tamasee DAR School, Epworth Children's Home, Connie Maxwell Children's Home, Generations group Homes, Inc., Carolina Youth Development Center, and Billie Hardee Home for Boys; in New York the pilot agency was Hillside Family of Agencies, Varick Campus.

In 2009, based on the success of the field test in the pilot agencies, The Duke Endowment, a private foundation serving North and South Carolina, awarded the RCCP a 5-year grant to support a comprehensive evaluation of the CARE model using a sophisticated quasiexperimental design (research methodology) involving 14 residential agencies in North and South Carolina. The results from this study were positive and have been distributed at conferences and in the journal articles previously listed on page 3 of this document.

**The Bronfenbrenner Center for Translational Research (BCTR)** was established to expand, strengthen, and speed the connections between cutting-edge research and the design, evaluation, and implementation of policies and practices that enhance human development, health, and well being. **The Residential Child Care Project (RCCP)** is one of several projects in the BCTR relevant to the lives of children, families, and care agencies. The RCCP's goal is to develop therapeutic residential environments that provide safe and appropriate psychosocial processes that promote child and youth development. Research efforts undertaken by the RCCP include studies to determine what contributes to safe and developmentally sound treatment in foster care environments and to identify the primary, secondary, and tertiary intervention protocols and strategies that produce and maintain the psychosocial processes and interactional dynamics in safe and developmentally sound therapeutic environments.

Web links:

**BCTR**      <http://www.bctr.cornell.edu>

**RCCP**      <http://www.rccp.cornell.edu>

In 2010, Dr. James Anglin conducted a grounded theory study of the implementation processes in the pilot agencies. Dr. Anglin's (Anglin, 2011) findings concluded that the starting point for any agency seeking to implement the CARE program model was the unequivocal commitment and "hands on" involvement of the senior leadership. Anglin found that support from the senior agency leadership was critical for successfully changing individual care workers' mindsets and for reinventing the organizational culture to embrace CARE practices and thinking. In addition, Anglin noted that this process was not linear, but rather a cyclical one in which agency members re-commit, re-embrace, re-understand, re-work, re-experience, and re-gain confidence in the CARE program model as an effective philosophy and approach to working with young people. In looking at Cornell's consultancy role, he concluded that the consultants/facilitators were instrumental in creating the context

for change through developing a level of trust with agency participants sufficient to allow for a supportively challenging engagement.

### **Objective of the CARE Model**

The CARE model aims to provide organizations with a set of research and standard-informed principles to guide decision making and practice choices that are in the best interests of the children and families they serve. These best practice principles provide carers with clear objectives for daily routines, leisure activities, and staff-client interactions, and establish a framework for all staff in their interactions with clients, other staff members, and external organizations. The goal of this program is to establish a framework for practice based on a valid theory of how children change, grow, and develop that is consistent with the needs of the children, motivates both children and staff to adhere to routines, structures, and

processes, and minimizes the potential for interpersonal conflict. A framework for practice provides consistency in message and approach with the children and families and congruency throughout the organization. In order for these principles to be integrated into practice, an agency's leadership must:

1. Support an organizational climate and culture that expects these principles to be integrated into practice
2. Develop professional learning and accountability systems to ensure their use on-the-job through reflective practice, data-informed decision-making, and creating a community of practice
3. Support participatory and collaborative management practices that address active use of data and data analysis to promote organizational learning that sustains and manages the CARE model and its long-term utilization

## Notes

# Implementing CARE in Your Agency

## Technical Assistance Offered

The CARE implementation strategy is designed in concert with key agency personnel. This process begins with the formation of a CARE implementation team, responsible for the coordination and monitoring of CARE activities, made up of key leadership and a cross section of agency personnel. The following shows the range of activities that might take place through quarterly visits throughout the life of the project:

1. Identify a core group of agency leaders to serve as the CARE implementation and integration group.
2. Perform organizational assessments including assessment of status of crisis prevention and management system, organizational culture/climate, current practice, and program.
3. Facilitate a leadership retreat with key leadership staff to help them plan how to integrate the CARE model throughout the agency.
4. Develop CARE educators within the organization to provide CARE training and staff development activities to all agency personnel.
5. Train agency supervisors in strategies and activities that provide support and accountability for the use of CARE principles.
6. Provide technical assistance to agency leadership to support CARE practices, to ensure long term maintenance and sustainability and to support, enhance and maintain the use of the CARE principles in daily activities throughout the organization, i.e. observations, implementation group meetings, case reviews, data collection and analysis support activities.
7. Work with agency personnel to develop the capacity to collect, analyze, and use data to make decisions regarding programming, training, and daily interactions with children, families, and staff.

## Sample Proposal/Scope of Work Agreement

The following pages contain a sample proposal/scope of work agreement for organizations interested in adopting CARE. If there are several organizations interested in adopting the program, the RCCP will discuss a system-wide implementation and evaluation proposal. If the organization does not have an effective crisis prevention and management system in place, a combination Therapeutic Crisis Intervention (TCI) and CARE implementation project can be developed.

# CARE Sample Proposal 2019: Scope of Work

## Overview

Cornell University's Residential Child Care Project proposes to work with agency in order to implement and integrate Children And Residential Experiences (CARE): Creating Conditions for Change program model throughout the organization. This residential care practice model will enable the agency to organize and deliver quality care of children according to evidence based principles based on the best interest of the child. The CARE model focuses on professional interactions and decision-making to provide for children's safety, permanency, and wellbeing. Cornell University is committed to assist agencies to design and support congruent organizational climates and cultures that support these principles and their implementation into professional practice and decision-making. This partnership with Cornell University would extend over a three-year period at a cost of \$130,000-\$178,000 (2020 fee schedule for US agencies) dependent on the size, scope and numbers of sites of the organization.

## Background

Developed in 2006 and listed on the California Evidence Based Clearinghouse (CEBC) in 2017 with a Scientific Rating of 3 (Promising Research Evidence) and a High Child Welfare System Relevance Rating(<http://www.cebc4cw.org/program/children-and-residential-experiencescare/detailed>), the CARE program model is designed to enable community child welfare and mental health professionals to organize and deliver congruent and quality care in the best interests of children and families according to six research and evidence based principles. These six research and standards-informed principles are designed to guide residential child care staff's practice and interactions with children in order to create the conditions for change in children's lives. The research-informed principles support care and treatment that is developmentally focused, family involved, relationship based, competency centered, trauma informed and ecologically oriented. These best practices principles are grounded in theory, in evidence-based practices, in practice wisdom, and in child care standards. The principles were established after literature reviews, surveys of experienced child care workers and supervisors, and standards reviews.

## Project Activities

The CARE integration and implementation strategy will be designed in concert with key agency personnel. This process begins with the formation of a CARE implementation group responsible for the coordination and monitoring of CARE activities made up of key leadership personnel. The following are the range of activities following are the range of activities that might take place through regularly scheduled visits (approximately 30-33 days on-site) throughout the life of the project as designed by the project implementation group:

1. Identify a core group of agency leaders to serve as the CARE implementation and integration group.
2. Perform organizational assessments including assessment of status of crisis prevention and management system, organizational culture/climate, current practice, and program.
3. Facilitate a leadership retreat with key leadership staff to help them plan how to integrate the CARE model throughout the agency.
4. Develop CARE educators within the organization to provide CARE training and staff development activities to all agency personnel.
5. Train agency supervisors, managers and clinicians in strategies and activities that provide support and accountability for the use of CARE principles.
6. Provide technical assistance to agency leadership to support CARE practices, to ensure long term maintenance and sustainability and to support, enhance and maintain the use of the CARE principles in daily activities throughout the organization, i.e. observations, implementation group meetings, case reviews, data collection and analysis support activities.
7. Work with agency personnel to develop the capacity to collect, analyze, and use data to make decisions regarding programming, training, and daily interactions with children, families, and staff.

### **Project Outcomes**

1. All personnel trained in the CARE principles with support will integrate those principles into their practice at the appropriate level.
2. Staff knowledge of CARE principles will increase as measured through knowledge based testing.
3. Staff will increase the use the CARE principles in their practice. (Measured through current practice surveys, observation, and supervision).
4. Children and young people will have improved perceptions of staff and staff behavior.
5. Numbers of incidents such as aggressive behavior, fighting, running away, property damage will be reduced as evidenced in agency's documentation and data collection system.
6. Training capacity to continue training staff in the CARE model will be developed.

7. A data collection system that allows staff to use data in decision-making throughout the organization will be established.

**Project Time Table** *(may vary according to the size and needs of the organization)*

**First Six Months**

- Establish implementation group and meet with Cornell implementation and data specialist staff team
- Conduct Surveys (Status of Crisis Prevention and Management System) to all staff
- Develop strategic plan for changes to organizational structure to accommodate crisis management model (if needed)
- Meet with agency personnel to review current data collection instruments and set up data collection process for evaluation/administrative data collection
- Conduct organizational assessment (including the University of Tennessee's OSC Culture/Climate Survey to be completed by 100% of agency personnel)
- Set up data collection and monitoring system for evaluation and feedback on CARE integration
- Conduct leadership retreat (4 days) to provide training in CARE principles, review survey results and develop a strategy for implementation/integration of CARE principles throughout organization, and delivery of training
- Schedule five day CARE training to develop agency CARE educators
- Monitor data collection and analysis for feedback and targeting technical assistance

**Second Six Months**

- Meet with implementation group to review survey results
- Conduct training of educators
- Plan for roll out of 5 day CARE training to all staff
- Meet with implementation group to review implementation plan and adjust plan if necessary
- Provide support to agency CARE educators as they train all agency staff and assist in setting up a schedule for on-going CARE training and refresher strategies
- Monitor data collection and analysis for targeting technical assistance



### **Second Year**

- Meet with implementation group to assess and make recommendations for CARE implementation
- Plan for mid term data collection and facilitate a mid-term leadership retreat
- Provide workshops/training sessions as indicated by on-going assessment of progress toward implementation/integration of CARE principles
- Provide support to agency CARE educators and assist in setting up a schedule for on-going CARE training and refresher strategies
- Provide technical assistance through observing program activities, interactions, group dynamics, and/or meetings
- Monitor data collection and analysis for targeting technical assistance

### **Third Year**

- Meet with implementation group to plan for sustaining and maintaining the CARE model
- Provide workshops/training sessions if indicated by on-going assessment of progress toward implementation/integration of CARE principles
- Provide technical assistance through observing program activities, interactions, group dynamics, and/or meetings
- Monitor data collection and analysis for targeting technical assistance

### **Final Quarter**

- Conduct post implementation surveys, testing, (i.e. the University of Tennessee OSC instrument and the relevant agency outcome instruments) to assess progress toward achieving goals on implementation plan
- Conduct a CARE review to assess level of CARE implementation/integration throughout the organization
- Meet with implementation group to continue the development the maintenance plan for CARE and provide results of post implementation surveys, testing, and CARE review
- Establish terms for on-going relationship between CARE agency and Cornell University and a timeline to apply for CARE certification

### **Cost of Project and Payment Schedule**

The cost of the CARE Implementation Project is \$130,000-\$178,000 (2020 fee schedule for US agencies) to be paid in quarterly payments over the three or four-year period. This cost includes the technical assistance and training services provided by Cornell University faculty and staff, travel costs incurred by Cornell University faculty and staff, training materials for training delivered by Cornell faculty, and survey materials. The schedule of payments can be adjusted if necessary. Payment is due upon receipt of the invoice.

### **CARE Certification and Sustainability**

At the completion of the active implementation period, the agency will enter into a three year on-going sustainability agreement that provides for on-going support and annual visits from the Cornell Consultants. Once the agency and Cornell have determined that CARE is fully implemented throughout the organization, the agency will participate in an assessment of fidelity to the CARE model for certification as a CARE agency. Certified CARE organizations will be supported while in sustainability by:

- Continued contact with CARE consultants and annual visits planned collaboratively with the agency to support CARE fidelity
- Access to regional and national CARE events
- Continued use of post-training surveys with review by CARE consultants and the agency
- Certified CARE agencies may be invited to participate as members of the CARE Academy, and may serve as mentors for organizations new to implementation

The cost for CARE sustainability is \$29,750.00 (2020 fee schedule for US agencies) for a three year period (paid in yearly installments). This cost includes the technical assistance and training services provided by Cornell University faculty and staff, travel costs incurred by Cornell University faculty and staff, training materials for training delivered by Cornell faculty, and survey materials. The schedule for payments can be adjusted if necessary. Payment is due upon receipt of the invoice.

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## Notes

# RCCP Faculty, Instructors, and Staff

## Extension/CARE Facilitation Team

**Martha J. Holden, M.S.**, is a Senior Extension Associate with the BCTR, principal investigator and Director of the RCCP. Ms. Holden provides technical assistance and training to residential child caring agencies, schools, juvenile justice programs, and child welfare organizations throughout the United States, Canada, the United Kingdom, Ireland, Australia, and Israel. She is the author of *Children and Residential Experiences (CARE): Creating Conditions for Change*, a best practice model for residential care organizations. Ms. Holden has published in the *Children's and Youth Services Review*, *Child Abuse and Neglect: An International Journal*, *Journal of Emotional and Behavioral Problems*, *Residential Treatment for Children & Youth*, and the *Journal of Child And Youth Care Work*. She has co-authored chapters in the books, *Therapeutic residential care for children and youth: Developing evidence-based international practice*; *For Your Own Safety: Examining the Safety of High Risk Interventions for Children and Young People*; *International Perspectives on Inclusive Education, Volume 2*, *Transforming Troubled Lives: Strategies and Interventions with Children and Young People with Social, Emotional, and Behavioural Difficulties*; *Understanding Abusive Families: An ecological approach to theory and practice*. Previously Ms. Holden served as an administrator overseeing the day-to-day operations of a residential treatment agency for adolescents, including its education resources.

**Kelly Dempsey, B.S.**, has been a TCI instructor since 2007 and joined the RCCP team in 2016. She has worked with youth in residential care settings since 2002, and has held positions such as therapeutic foster parent, milieu supervisor, and training specialist. She is currently a

Unit Director at a residential treatment facility serving adolescents with complex trauma, developmental disabilities, and mental illness with Spurwink, located in Portland, Maine. She provides TCI and CARE training for new and existing employees and assists in the implementation of the TCI system within Spurwink and other contracted community organizations.

**Thomas J. Endres, M.A.**, is an extension associate with the BCTR. Mr. Endres has extensive experience working in residential and group care settings. He has held multiple positions including residential supervisor, clinician, program management and development. Mr. Endres provides training and technical assistance to agencies implementing CARE and TCI across North America.

**Richard Heresniak** has worked in school and residential care settings since 1985 in a variety of capacities including direct care, school support services, supervisor, and staff training/development coordinator. Richard was the first professionally certified TCI trainer and was a consultant with the Residential Child Care Project from 2003 until 2018, when he was hired as a full time staff with Cornell. He provides training and technical assistance in TCI, TCIS, and CARE. His work with the project also includes curriculum design and development, as well as providing written contributions to project communications.

**Franklin Kuhn, Jr., Ph.D.**, is a Senior Extension Associate with the BCTR. A clinical psychologist, Frank has worked in clinical, educational and administrative positions with child welfare organizations and universities for over 35 years. He has served as medical school faculty and has provided consultation and training to

agencies across the U.S and Canada. Dr. Kuhn coordinates CARE implementation throughout North America. He currently serves on the editorial board of the *International Journal of Child, Youth and Family Services*. Research interests include implementation and evaluation of program models in human service organizations and facilitation of positive organizational change.

**Mary Ruberti, LMSW**, is an extension associate with the BCTR. Ms. Ruberti has worked in child welfare and residential treatment for over 25 years in various roles including direct care worker, supervisor, social worker, training coordinator, and quality assurance manager. Ms. Ruberti has been affiliated with the Residential Child Care Project at Cornell since 1993. She has had the privilege of providing training and technical assistance to agencies implementing Therapeutic Crisis Intervention (TCI) and Children and Residential Experiences (CARE) across North America.

**Andrea Turnbull, M.A., LMHC, QS**, is an extension associate with over 20 years experience working with young people in residential and foster care settings. She has held positions such as direct care worker, milieu coordinator, program director, training director and clinical coordinator. In addition to her work as a TCI/CARE instructor providing training and technical assistance for the Residential Child Care Project, she also helps coordinate the TCI program.

## Research and Evaluation Team

**Michael Nunno, D.S.W.**, is a Senior Extension Associate with the Bronfenbrenner Center for Translational Research (BCTR), and the co-principal investigator of the RCCP. He has

expertise in social policy, regulation, and legislation related child welfare issues as well as specific expertise in the identification, prevention, and etiology of child abuse and neglect in residential care. More recently Dr. Nunno has been working with therapeutic and residential child-care organizations to measure the impact of Cornell University's Therapeutic Crisis Intervention system and its Children and Residential Experiences program model on critical incidents. Dr. Nunno has published in the *Child Protective Services Team Handbook*, as well as in *Children and Youth Services Review*; *Child and Youth Care Forum*; *Child Welfare*; *Child Abuse and Neglect: An International Journal*; *Children and Society*; *Protecting Children*; *The American Journal of Orthopsychiatry*; *Psychiatric Services* and the *Journal of Child and Family Studies*. He was editor of the *Journal of Child and Youth Care's* dedicated issue on institutional maltreatment and coeditor of the book, *For Your Own Safety: Examining the Safety of High-Risk Interventions for Children and Young People*.

**Charles Izzo, Ph.D.**, studied Clinical Psychology with a specialty in the design and evaluation of community-based services to improve family functioning. His work has focused on applying social science research and methods to improve the quality of human service programs, particularly those that target caregiving. He has published in journals such as *Prevention Science*, *International Journal of Child and Family Welfare*, and the *Journal of Prevention and Intervention in the Community*.

**Elliott G. Smith, Ph.D.**, is a developmental psychologist with methodological expertise in experimental psychology and statistical analysis. He specializes in issues related to child maltreatment and child welfare. He is a Re-

search Associate at the Bronfenbrenner Center for Translational Research at Cornell University where he serves as Statistician and CARE Data Specialist for the Residential Child Care Project. In his research, Smith evaluates the effectiveness of the Children and Residential Experiences (CARE) program model and the Therapeutic Crisis Intervention (TCI) System. His implementation efforts center around providing quantitative data back to practice professionals in ways that are approachable, motivating, and actionable. His published research has appeared in numerous journals, including *Child Welfare*, *Developmental Psychology*, *Journal of the American Medical Association*, *Pediatrics*, and *Prevention Science*.

**Lisa McCabe, Ph.D.**, is a Research Associate in the Bronfenbrenner Center for Translational Research and Director of the Cornell Early Childhood Program at Cornell University. Her research focuses broadly on early childhood education and care issues. Current and recent projects have examined supports for professional development, program fidelity, and quality in a variety of settings including residential child care programs, family child care homes, and child care centers.

**Deborah E. Sellers, Ph.D.**, is the Director of Research and Evaluation for the BCTR. She is a sociologist specializing in quantitative research methods who received her PhD from the University of Massachusetts-Amherst and a MS in biostatistics from the Harvard School of Public Health. Before coming to the BCTR Debbie was the Principal Research Scientist and Director of Research and Development at the Center of Applied Ethics, Division of Health and Human Development at the Education Development Center in Waltham MA. where she served as project director on five multi-year,

multi-component research projects (e.g. Goff, Sellers, et al, 1998; Dawson, Sellers et al, 2005; Solomon, Sellers et al, 2005; Sawicki, Sellers, & Robinson, 2008; Sellers et al, in press).

**Kristen Carlison** supports the data management needs of the RCCP. Within these duties she manages the data needs of TCI's certification and testing system, she manages and oversees both the TCI and CARE databases, as well as TCI and CARE implementation projects. She also has responsibilities for the project's quarterly reports, budget proposals, and proposal development.

**Trudy Radcliffe, B.A.**, is the primary contact person for CARE, a program model for residential services. She coordinates CARE training, registration, evaluation, data collection, processing, reporting, and project logistics. She also assists with the coordination of CARE and TCI research efforts. She has worked in the human service field for over 30 years. Before coming to RCCP she worked with children, families and educators in the early childhood education field teaching, mentoring, and consulting. She has presented at both state and national conferences on program and curriculum development, and is happy to continue advocating for children and families with RCCP.

## RCCP CARE Consultants

**Jennifer Appleby, MSW**, has worked as both a clinician and as an administrator for the past 14 years as part of Spurwink services day and residential programming. During this time she also provided CARE training, and served on various agency wide committees serving the clinical needs of children and families, as well



as the training and coaching of staff. During her tenure at Spurwink, Jen was also instrumental in creating arts and recreation programming, securing grants to provide materials; renovating a space; and training staff on the use of games, arts and activities as meaningful therapeutic interventions. Jen has recently moved into private practice where she continues to serve children and their families.

**Debra Bunce, Ph.D.**, is the Director Clinical Practices at Spurwink Services, a large non-profit human services agency serving youth, adults, and families in Portland Maine. Debra began her career as a childcare worker in residential treatment in 1992. She shifted to graduate school and was awarded her PhD in Child Clinical Psychology in 1999. She spent the first part of her professional career primarily engaged in psychological testing, individual and family therapy, and clinician training. In 2011, She moved into her current role providing clinical support, guidance, and training to Spurwink's children's residential programs and schools all located within a couple hours of Portland. In this role, Debra has also overseen the development and implementation of Spurwink's clinical model, which is grounded in CARE principles and practices. Debra has been a CARE educator since 2012 and was very pleased to join RCCP's consultant team in 2017, providing education and technical assistance to new CARE agencies while continuing to develop and improve on CARE practices at Spurwink.

**Sharon Butcher, M.A.**, is the Director of Education at the Waterford Country School, a non-profit human service agency located in southeastern Connecticut. Her professional career began as a childcare worker in the residential treatment program at WCS before becoming

a Special Education Teacher and advancing into her current role. In addition to being a TCI trainer for her agency Sharon is also also a CARE trainer and is deeply devoted to the sustainability of the CARE model in the school.

**John Gibson, M.S.W., MSSc, CQSW**, is owner of Secure Attachment Matters – Ireland. He is qualified in Social Work and has worked in 4 different residential child care settings for a total of 21 years. He consults to residential child care organizations, principally in relation to development of models of care. He provides direct support to high risk foster placements, working systemically with all significant parties. He was among the first workers to train in TCI in Ireland and Britain. He joined RCCP as an Instructor in 2001. He holds post graduate qualifications in Social Learning Theory (Child Care) and in Social Work Management and Leadership. He is trained in the Child Attachment Interview at the Anna Freud Centre (London).

**Jack C. Holden, Ph.D.**, has been an instructor and project consultant with Cornell University's RCCP for nearly 30 years. Dr. Holden earned a Ph.D. in Education, specializing in Adult Learning and has presented workshops and research nationally and internationally and has authored, *Developing Competent Crisis Intervention Training*, and co-authored a chapter, *Preventive Responses to Disruptive and High-Risk Behaviours*, in the book *International Perspectives on Inclusive Education*. Dr. Holden has co-authored several training manuals including *Therapeutic Crisis Intervention for Schools*, (TCIS) and published in the *Journal of Child and Youth Care Work*, and *Journal of National Staff Development and Training Association*.

**William Martin, MHSA**, has been working with children and families with special needs for over 30 years. He is the Executive Director of Waterford Country School, a non profit human service agency providing a multitude of services including residential treatment, emergency shelters, safe homes, group homes, foster care, education, and in-home services. Bill is also a CARE and TCI instructor and he and the staff of Waterford Country School are deeply involved in, and committed to TCI, TCIF, TCIS and the CARE and CARE for Foster Carers program models. Bill has a Master's degree in Human Service Administration and a Bachelors Degree in Social Work.

**Anton Smith, Executive Director, MSW, RSW**, has worked at Oak Hill for over ten years and in Child and Youth Care for over 30 years. Anton has completed a Masters in Social Work (2005) through Dalhousie University in Child and Family Practice and a Bachelor of Social Work from the University of Victoria. Anton has presented at international, national and regional conferences on topics related to Child and Youth Care. He has published two peer-reviewed articles in the areas of residential treatment and restraint reduction. He is professionally certified TCI trainer and a CARE trainer through Cornell University and he also has a strong interest in research.

**Angela Stanton-Greenwood, MA, MEd, CQSW** has worked with individuals with complex needs for over forty years as a practitioner with Barnardos in residential care and education and now as Director of Quality Assurance and Workforce Development in the Hesley Group England. She is a TCI and Proact SCIP R UK instructor and Positive Behaviour Support Coach. Angela is supporting CARE implementation and administers CARE and TCI through The Listening Post in Europe.

**Barbara Wells** is Principal of Wells Communications Consulting, a graphic design firm located in Jupiter, FL. Barbara has worked with the RCCP, designing materials for print and web distribution since the early 1980s. Wells Communications Consulting work was selected by Graphis Press, NY, NY, for publication in *Branding USA*, 2011 & 2009, and was one of 50 US graphic design firms showcased in *DesignersUSA3*.



