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IRVINE

Slumcare and the Fail-State

DISSERTATION

Submitted in partial satisfaction of the requirements  
for the degree of

DOCTOR OF PHILOSOPHY

in Criminology, Law and Society

by

Kenneth Alexander Cruz

Dissertation Committee:  
Professor Elliott P. Currie, Chair  
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2016



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## **CURRICULUM VITAE**

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## ABSTRACT OF THE DISSERTATION

Slumcare and the Fail-State

By

Kenneth Alexander Cruz

Doctor of Philosophy in Criminology, Law and Society

University of California, Irvine, 2016

Professor Elliott P. Currie, Chair

In this empirical study of an evidence-based intervention with aggressive and violent adolescent males, I show how the state repeatedly fails Native American youth, their families and their communities. Using grounded theory methods with a critical realist lens, I demonstrate how the provision of substandard care to the poor—what I call, *slumcare*—was enabled, justified and allowed to continue. In particular, I reveal how slumcare is the result of the state’s repeated failure to achieve its mandate of balancing quality care with other priorities. In this account of how poor quality care persists, I show how a form of governing I call the *fail-state* enables slumcare to emerge and linger. In addition, this study demonstrates that practitioners of evidence-based ‘conformist’ interventions can be a surprising resource for discovering ‘transformative’ solutions.

## Introduction

“There can be no keener revelation of a society’s soul than the way in which it  
treats its children.”

Nelson Mandela

When I put in my two-weeks notice at Mountain View,<sup>1</sup> I wrote in my research journal: “I feel like I am trying to stop an avalanche . . . It no longer feels like a group-home where staff run the house” (Journal Notes). In my last few entries—written after I had collected my interviews for this study—I reveal how emotionally painful it was to see chaos become the norm at the group-home I worked at for more than a year and how most of the new staff simply didn’t have what it takes to work with troubled youth. In my final entry, I wrote “[n]ow, the kids run the house, don’t follow the rules, and don’t listen to staff. It feels like chaos.” Although my shifts were generally run without a single crisis, our staff-log revealed that crises became the norm with our new staff. Tina—the regional manager—went out of her way to tell me she missed me and that “supervision of the kids has gone down since I left” my fulltime position to work one shift a week. Despite Tina’s wish that she could “clone” me, I felt “powerless.” No matter how hard I tried, I couldn’t prevent the collapse of what I helped to maintain for the better part of a year.

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<sup>1</sup> To protect the anonymity of my participants, I have created fictitious names for my participants, the company I worked for, the group-home where I worked, the location of the group-home and the Native American tribes that have been affected by the findings of this study.



During those last few months, Luna—the group-home manager—was fired and three of our strongest direct-care workers left the job as a result. The core group of staff I worked with for almost a year had all left at the same time and were replaced by new staff who generally couldn't run a shift without something going seriously wrong. Although Luna was reportedly fired for “insubordination” (Journal Notes), it was well known that she—along with a core of strong staff—held Mountain View together and prevented it from imploding. In my final entry, I reflect on how different things were just a few months before: “[w]hen I was working fulltime and we still had a core of strong staff, we ran a program that was structured. Not only were rules followed, the kids were proud of letting us know they were following the rules. Consistency across shifts was never fully attained, but the odd shift dominated by weak staff was the exception to the rule” (Journal Notes). Further, when Luna and I were colleagues, it was evident that the kids gravitated towards her and clearly benefitted from their connection with her. Indeed, she was commonly recognized as a *natural* in this line of work. In fact, as she tells it, it was her advocacy for the kids that ultimately got her fired.

Regardless of why she was terminated, after Luna and the core of Mountain View's staff left, chaos took a hold of the program on most days of the week and I couldn't bear to be associated with it any longer. So, I left as well and—to this day—I still carry the guilt of having abandoned the kids at Mountain View.<sup>2</sup> Although it may not assuage my guilt, I feel a tremendous responsibility to share the stories I collected of what it was like to work there and why even a core of strong staff couldn't prevent substandard care from occurring.

As this empirical study will show, the layers of dysfunction in this evidence-based program were too great and the sources of that dysfunction too far removed for us to control.

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<sup>2</sup> Two weeks before I put in my notice, I wrote: “It pains me to see the house in chaos and to see the look of abandonment in the kids' eyes” (Journal Notes).

Even the CEO of Adolescent Behavioral Care (ABC)—the for-profit company that owned and operated Mountain View—was often powerless. Despite good intentions, even he couldn't prevent the provision of substandard care to the poor: what I call, *slumcare*.

As manifestations of poor quality care, the slumcare practices detailed in this study—such as the facilitation of chaos and systemic endangerment—were not only substandard, they were also linked to harmful interventions. Because the harms produced by these practices are both widespread and destructive, it is urgent that we understand how they are produced and how they are enabled to persist. What this study will show is that it is the state that is ultimately responsible for the provision of slumcare. In particular, it is what I call the *fail-state*—a form of governing that repeatedly fails to achieve its mandate—that is heavily responsible for the substandard care detailed throughout this empirical analysis.<sup>3</sup> Although Mountain View is a single case of poor quality care, the insights derived from this study indicate that slumcare is enabled by the structure of Medicaid managed-care in this state: a structure that happens to be quite ubiquitous. It is my hope that this study will contribute to the structural harm literature by identifying how slumcare is enabled to persist.

### The Structural Harm Literature

In the last few decades, a growing body of interdisciplinary research has begun to examine how the structuring of society leads to a variety of social harms (Alexander, 2010; Beckett & Sasson, 2004; Biehl, 2005; Bourgois & Schonberg, 2009; Currie, 2004; Farmer, 2004;

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<sup>3</sup> Rothman (1980) argues that substandard interventions are the result of institutional conveniences and that “when conscience and convenience met, convenience won” (1980: 10). This study, however, reveals that substandard care often occurred in spite of institutional conscience. In fact, many of my colleagues were deeply committed to the services they were providing for troubled youth. Nevertheless, they were often constrained by structures beyond the control of the institution. Further, although implementation failures were connected to some slumcare practices, others were the direct result of fidelity to the state-supported interventions they were providing. That is, conscience—at the state-level—was often implicated in slumcare.

Galtung, 1969; Price, 2012; Richie, 2012; Roberts, 2002; Scheper-Hughes, 2004; Waquant, 2009). While the academic disciplines that house these works are as varied as the theories and methods they use, their central findings are substantively similar and disturbingly clear: the structuring of society can lead to dire consequences for some groups more than others. Indeed, the startling revelation of this body of work is that some of our valued—and taken-for-granted—policies, institutions and practices are routinely harming women (Price, 2012; Richie, 2012), children (Currie, 2004; Scheper-Hughes, 2004), and the forsaken (Alexander, 2010; Biehl, 2005; Beckett & Sasson, 2004; Bourgois & Schonberg, 2009; Farmer, 2004; Roberts, 2002; Waquant, 2009).

The structural harms unearthed by these works are captured in a variety of concepts including *social exclusion* (Young, 1999), *zones of social abandonment* (Biehl, 2005), *lumpen abuse* (Bourgois & Schonberg, 2009), *the new Jim Crow*, (Alexander, 2010), *the prison nation* (Richie, 2012), *punitive containment* (Waquant, 2009) and *structural violence* (Farmer, 2004; Galtung, 1969; Price, 2012; Richie, 2012; Scheper-Hughes, 2004). Although the concept of *structural violence*—violence that is “exerted systematically” through the reproduction of a given “social order” (Farmer, 2004, p. 307)—is broad enough to encompass all of the structural harms referenced above and was intended to extend the everyday understanding of violence, it remains advisable that “some level of precision is necessary” (Galtung, 1969, p. 167). Thus, while our common understanding of violence may need to be extended to include racism, sexism, and extreme inequality, it has been argued that the expansion of the concept of violence “should be a logical extension” (Galtung, 1969, p. 168). Indeed, while the harms revealed in this study are “built into the structure” (Galtung, 1969, p. 171) of society and implicate the “social machinery of oppression” (Farmer, 2004, p. 307), it would be a stretch to refer to all slumcare

practices as either violent or abusive. Although abusive practices are implicated in slumcare, the structural harms detailed here are often more subtle and more difficult to identify, but no less harmful as they include devastating injuries to personal dignity, emotional wellbeing, and cultural integrity. It is my hope that by adding further nuance to the structural harm literature, slumcare will be recognized as one of the myriad ways that the structuring of our society produces needless suffering (see Farmer, 1996, Farmer, 2004).

In addition to the structural harm literature, this study also contributes to our understanding of what works in group-care. That is, this critical examination of an evidence-based group-home not only shows how evidence-based interventions can be sites of structural harm, but also how important it is to examine how these programs work in practice.

#### What Works in Group-Care

In the field of youth care, group-homes occupy the intersection of our child welfare, behavioral health and juvenile justice systems (Chow et al., 2014). These home-like facilities serve as community-based alternatives to more restrictive settings and are generally intended to address the behavioral problems of their wards (Chow et al., 2014; Scott & Lorenc, 2007). Child protection case workers, juvenile court probation officers, legal guardians and parents tend to place children and adolescents into group-homes as either an alternative to institutionalization—such as juvenile detention or psychiatric hospitalization—or as a step down from institutionalization (Scott & Lorenc, 2007). The interventions provided by group-homes vary tremendously (Chow et al., 2014) and have sparked controversy when linked to adverse outcomes, such as increased risk for future arrests (Henggeler & Schoenwald, 2011; James, et al., 2012; Lee et al., 2011; Robst, et al., 2013; Ryan et al., 2008). Nevertheless, proponents have maintained that some group-home interventions are superior to others (Scott & Lorenc, 2007). In

particular, behavioral models of intervention have been heralded as effective and evidence-based in reducing behavioral problems (De Swart et al., 2012; James, 2011; Knorth, et al., 2008; Larzelere, et al., 2001; Larzelere, et al., 2004; McCurdy & McIntyre, 2004; Sinclair, et al., 1995; see Hair, 2005; James et al., 2012; Taussig, et al., 2007).

In terms of scope, hundreds of thousands of children are removed from their homes each year and placed into a slew of out-of-home settings in the contemporary United States (Conn, et al., 2013). Although some of these children do need to be removed for their own safety and, at times, for the safety of others, mounting evidence indicates that child removal is often unnecessary (Barth, et al., 2007; Eamon & Kopels, 2004; Kyte, et al., 2013; Loman & Siegal; 2012; Roberts, 2002; Swenson, et al., 2010) and is—all too often—biased against particular racial groups and social classes (Alliance for Racial Equity in Child Welfare, 2011; Ards, et al., 2012; Carter, 2009; Crofoot & Harris, 2012; Harris & Hackett, 2008; Laskey, et al., 2012; Roberts, 2002; Wulczyn, et al., 2013). Compounding the overzealousness and biases of child removal is the fact that many of these out-of-home settings reproduce the very harms they're intended to prevent—child abuse and neglect (Hyde & Kammerer, 2009)—and often fail to address the behavioral and emotional troubles of their wards (De Swart, et al., 2012; Ryan et al, 2008; Unrau, et al., 2008). Although great strides have been made in decreasing the utilization of out-of-home placements (Conn, et al., 2013) and in improving the quality of foster homes and group homes, poor quality sites are pervasive and the harms they produce within their communities remain out-of-sight and out-of-mind (see Hyde & Kammerer, 2009).

While academics continue debating how effective out-of-home placements are in producing narrowly defined outcomes with troubled youth (Barth et al., 2007; De Swart, et al., 2012; James, et al. 2012; Knorth, et al., 2008; Lee, et al., 2011; Robst, et al., 2013; Robst, et al.,

2011; Scott & Lorenc, 2007), the manner in which those outcomes are achieved in practice tends to get lost in the discussion and ignored in far too many studies (see Gallagher & Green, 2012; Freundlich & Avery, 2005). That is, the narrow focus on what works in transforming the behaviors of troubled youth often fails to examine how practitioners experience the implementation of these models of intervention and how they are experienced by the youth they serve (see Hyde & Kammerer, 2009). Insights into how these interventions are experienced by those most directly involved are crucial to our understanding of how beneficial they actually are (see Currie, 2004).<sup>4</sup> Thus, there is a critical need to balance the quantitative evidence of what works in statistical models with qualitative evidence of how interventions work on the ground (see Goodkind, et al., 2011; Knorth, et al., 2003; Knorth, et al., 2008). It is my hope that this study can contribute to our understanding of how these programs work in practice and why it is time to move beyond what works to what is just. However, to understand how justice is implicated in sites such as Mountain View, it is necessary to address the history of child-saving institutions.

### The Missionary Logic of Child-Saving

To understand the present day ubiquity of group-homes such as Mountain View, it is important to understand their historical roots (see Farmer, 2004, p. 309).<sup>5</sup> Indeed, a critical

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<sup>4</sup> In this regard, this study also adds to the literature of “total institutions” (Goffman, 1961, p. xiii; see Rhodes, 2004, Luhrmann, 2000, Rhodes, 1991, Rothman, 1980). In particular, this study is largely an examination of the discrepancies “between what the institution does and what its officials must say it does” (Goffman, 1961, p. 74). Indeed, as a study of “the *underlife* of the institution” (p. 199), it examines how a “multiplicity of conflicting official goals” is experienced (p. 176) and often managed through “*secondary adjustments* . . . by which a member of an organization employs unauthorized means, or obtains unauthorized ends” (p. 189).

<sup>5</sup> To understand structural harms, Farmer (2004) argues that “historically deep” analyses are “critical” (p. 309). Without it, ethnographic research runs the risk of focusing narrowly on “current events and the ethnographically visible.” That is, researchers “who look only to

examination of the historical literature reveals that a missionary logic of child-saving has underscored repeated efforts to convert impoverished and troubled youth into conformity with mainstream culture while leaving the conditions they come from virtually untouched (Feld, 1999; Katz, 1993; Krisberg, 2005; Mennel, 1973; O'Connor, 2001; Platt, 1977; Rothman, 1980). The taken-for-granted assumptions of this logic are that wayward youth need to be saved from themselves, their families and their communities and that mainstream cultural missionaries are needed to save them. Although this logic recognizes that structural disadvantages are implicated in treacherous living conditions, familial distress and troublesome behaviors, it nonetheless assumes that interventions should be focused on teaching children how to adjust to those disadvantages, rather than eradicating them in the first place. According to this way of thinking, if the child can learn to behave properly and develop the necessary skills, she can escape the ghetto. If the child of concentrated disadvantage can learn to control himself, he can avoid imprisonment and obtain a decent job.<sup>6</sup> Within the limits of this logic, fixing harmful structural arrangements—such as de facto segregation and resource deprivation—is presumed to be unnecessary; if not—merely—unthinkable (see O'Connor, 2001).

In the process of preaching behavioral conformity, this logic invalidates resentment, desperation and anger as either reasonable or normal responses to the harmful realities of unequal schooling, unsafe housing, unlivable wages, unequal surveillance and persistent segregation (see Markowitz & Rosner, 2000). Indeed, its implicit function has always been the sanctification of the status quo. According to this reasoning, saving children through behavioral

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powerful present-day actors to explain misery will fail to see how inequality is structured and legitimated over time” (p. 309).

<sup>6</sup> Although the bulk of evidence shows that escape from the ghettos of the United States is exceedingly difficult (Sampson, 2008a; Sharkey, 2013) and that avoiding police harassment in these neighborhoods is nearly impossible (see Beckett et al., 2006; Rios, 2011; Solis et al., 2009), this logic continues to push the mythology that the American Dream is equally accessible.

conformity seems logical while dedicating resources to empower entire communities is unimaginable. In fact, the inability to contemplate how areas of concentrated disadvantage can be empowered and integrated into the larger society is indicative of the degree to which de facto segregation and extreme inequality are accepted as normal in the United States. However, it is unfair to suggest that empowering these communities has not been imagined or attempted. In fact, for as long as there has been a missionary logic of child-saving, there has also been an empowering logic of community-building. Unfortunately, the latter has never fully captured our national conscience.

Whether it was the houses of refuge of the 1820s, the placing-out practices of the 1850s, the reform schools of the 1880s, or the juvenile court approaches of the 1900s, the central logic of saving children from themselves, their families and their communities dominated most of the interventions instituted under the progressive banner (see Feld, 1999; Krisberg, 2005; Menzel, 1973; Platt, 1977; Rothman, 1980).<sup>7</sup> Although these missionaries were motivated by a humanitarian impulse to save children from the horrid conditions of jails, they were also attempting to save themselves from a potential class uprising (Feld, 1999; Krisberg, 2005; Menzel, 1973). However, rather than dedicate themselves to improving the conditions of impoverished communities, they sought to remove the ‘offending offspring of the poorest, most ignorant, most degraded and suffering members of our community’ and place them into institutions where they would be disciplined through ‘a mental and moral regimen’ (Menzel, 1973, pp. 11-17; see Katz, 1993). During the 1850s, organizations such as the “Children’s

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<sup>7</sup> In the United States, the first organized attempt to implement the missionary logic of child-saving took place shortly after the depression of 1819, when conservative and wealthy philanthropists—who proclaimed themselves to be “God’s Elect”—opened and operated houses of refuge in Northeastern cities to “correct the behavior” of impoverished and troubled youth (Menzel, 1973, p. 5, see Feld, 1999; Krisberg, 2005).



Mission to the Children of the Destitute” and the “Five Points Mission” instituted a practice of placing out youth with farm families out west to reform them through agricultural discipline. Although a degree of humanity motivated the “anti-institutional” zeal of these missionaries, they were also motivated by fear and bigotry against the ‘dangerous classes’ (Mennel, 1973, pp. 34-35; see Feld, 1999; Krisberg, 2005; Platt, 1977). Instead of imagining how inner city communities and families could be saved from resource deprivation, these missionaries focused on ‘draining the city’ of impoverished and troubled children (Mennel, 1973, p. 37; see Katz, 1993).

In the 1880s, the missionary logic found powerful support in the biological and psychological explanations of wayward behavior (Feld, 1999; Krisberg, 2005; Mennel, 1973; Platt, 1977; Rothman, 1980). Backed by the prestige of psychiatry, this new iteration of child-saving missionaries adopted the language of diagnosis, disease and treatment as they attempted to cure the maladjusted child (Mennel, 1973; Platt, 1977; Rothman, 1980). Like their predecessors, the mission was not to empower and integrate historically exploited and abandoned communities, but to identify which individuals could be salvaged. In fact, it was taken-for-granted that the defective should be segregated and it was assumed that inequality and deprivation were inevitable for those who could not be saved (Mennel, 1973; O’Connor, 2001; Rothman, 1980). However, it was also widely believed that children, in particular, could be saved from the presumed pathologies that infected their communities and that reformation and correction of habits could cure the maladjusted child (Mennel, 1973; Platt, 1977; Rothman, 1980). In addition, the “child-study movement” called upon middle-class women—in particular—to serve as “guardians of morality” and to carry out the ‘civilizing mission’ of mainstream society (Feld, 1999, p. 32; see Elias, 2000).

Not only did biological and psychological explanations provide powerful scientific justifications for the missionary logic of saving children, but they also rationalized the status quo (Feld, 1999; Krisberg, 2005; see Conrad & Schneider, 1992; Markowitz & Rosner, 2000) and supported the taken-for-granted bigotry of the times (Feld, 1999; Katz, 1993; Mennel, 1973; Platt, 1977; Rothman, 1980). Indeed, as the reformatory zeal of this logic took hold of the nation at the end of the nineteenth century, not only were children from inner cities increasingly placed into state reform schools (Mennel, 1973), but children from Indian reservations were also forcibly removed from their families—as a matter of federal policy—and placed into Indian boarding schools intended to ‘kill the Indian and save the man’ (Smith, 2005, p. 36, see Mihesuah, 2003). Within these boarding schools, Native American children were intentionally stripped of their language and culture in addition to being exposed to inhumane conditions and horrific treatment (Crofoot & Harris, 2012; Gone, 2009; Jacobs, 2004). While attempts at cultural genocide (Smith, 2005) represented some of the darkest expressions of the pathological assumptions attributed to non-mainstream cultures, the missionary logic of saving children from themselves, their families and their communities continued to be presented as a compassionate way of thinking that was backed by science (Platt, 1977). Indeed, many of the progressive thinkers of the time “shared an unprecedented faith in the potential of institutions . . . to reform society through their impact on individual personality and behavior” (Katz, 1993, p. 474).

By the 1930s, the allure of psychiatry had fully captured the child-saving conscience of our nation and was comprehensively adopted by the burgeoning juvenile courts (Feld, 1999; Mennel, 1973; Rothman, 1980; see O’Connor, 2001). In fact, the mission to “rescue and rehabilitate” impoverished and troubled children (Rothman, 1980, p. 233) was enthusiastically embraced by juvenile court judges who “shared the missionary passion of the child savers and

approached their work in medical-therapeutic terms” (Platt, 1977, p. 145). In addition, the social worker and the juvenile court probation officer took the “crusading spirit of psychiatry” (Rothman, 1980, p. 306) into the community to reform youth, their families and their neighbors (Feld, 1999; Markowitz & Rosner, 2000; Mennel, 1973; Rothman, 1980).<sup>8</sup> While social workers’ and juvenile probation officers’ diagnoses of the problem would extend beyond the child to include assessments of the family and the child’s community, the child-saving imagination would not investigate the larger structural arrangements that boxed these communities into the isolated corners of our society (Markowitz & Rosner, 2000; Mennel, 1973; Rothman, 1980). Altering the structural arrangements that produced distress, desperation, and trouble in the ghetto and the reservation were simply beyond the grasp of the missionary logic. Like the earlier iterations of child-savers, their mission wasn’t to address the structural arrangements that produced desolation within these communities, but to promote psychological adjustment to those conditions and to serve as ‘missionaries from the dominant culture’ (Feld, 1999, pp. 63-64). Further, it should never be forgotten that—although the child-saving conscience was partially motivated by humanitarian impulses—the child-saving institutions of the time were both racially segregated and highly discriminatory against black youth (Markowitz & Rosner, 2000; Platt, 1977; Ward, 2012). That is, many child-saving institutions believed that black youth were not even worth saving.

Although the psychological approach of adjusting the maladjusted encountered both intellectual and political challenges during the War on Poverty in the 1960s (Cazenave, 2007;

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<sup>8</sup> Although the profession of social work was initially focused on ‘removing the conditions’ of resource deprivation and spurring “corrective civic action” on behalf of children (Mennel, 1973, p. 152), the social worker soon became an “adjunct to the psychiatrist” (Rothman, 1980, p.315; see Hunter, 1964) and was redeployed to diagnose and intervene based on the psychological assumptions of maladjustment (Markowitz & Rosner, 2000; Mennel, 1973; Rothman, 1980).

Hunter, 1964; Markowitz & Rosner, 2000; Mennel, 1973) and was derailed during the closing decades of the twentieth century (see Cullen & Gendreau, 2001), it is reemerging in the United States with increased vigor (see Cullen, 2006; Drake, et al., 2009; Greenwood, 2008; Henggeler & Schoenwald, 2011; Welsh, et al., 2013). In fact, the juvenile justice mental health movement is presently on the cusp of thoroughly medicalizing the problems of troubled youth (see Grisso, 2007) as new diagnostic procedures are finding that close to eighty percent of juvenile delinquents—who also happen to be overwhelmingly impoverished—are meeting criteria for behavioral and mental health disorders (Karnik, et al., 2009; see Fazel, et al., 2008; National Center for Mental Health and Juvenile Justice, 2006). Today, new therapeutic approaches are being increasingly advocated as more humane and more effective than the punitive approaches that resurfaced and took hold in the 1980s and 1990s (see Cullen & Gendreau, 2001; Cullen, 2006; Greenwood, 2008; Henggeler & Schoenwald, 2011; Welsh & Farrington, 2012). However, what tends to get lost in pitting therapeutic child-saving against punitive jailing is the fact that a more humane and socially just way of thinking about troubled youth, distressed families and disadvantaged communities has always been within our reach, even if difficult to grasp.

#### Transformative Intervention

According to Currie (2013a), too much of what passes for intervention today is what he calls ‘conformist’ intervention (p. 5). That is, interventions that focus on “getting people to accept the typically bleak conditions of life that have put them at risk, or turned them into ‘offenders’, in the first place” (Currie, 2013a, p. 5). In-step with the missionary logic of the past, these contemporary interventions “locate the source” of the problem within the individual and attempt to “train vulnerable people” to adjust to and manage their “chronically marginal lives and stunted opportunities” (Currie, 2013a, p. 5). Although these interventions often work at

producing barely noticeable, but statistically significant, changes in behavior, they fail to “address the most powerful forces affecting the lives of the people they’re designed to help” (Currie, 2013a, p. 5).

In a study of troubled—middle class—youth, Currie (2004) found that the interventions of ‘helping’ professions tended to compound “the effects of punitive or neglectful families” as these youth were often “left to manage—or to flounder—on their own” (pp. 123-125). Although Currie (2004) notes that “the poor” have “suffered the most” from the retrenchment of social services and the “lack of resources” for basic ‘aftercare,’ middle class youth have also been affected by a system of care in which it was “no one’s job to track down still-troubled, still-endangered children after they had been discharged” from behavioral health services (p.126). Not to mention that when they received services “their experience with what purported to be helping agencies was often painful, intimidating, and sometimes bizarre” (Currie, 2004, p. 128). As reported by Currie (2004) “again and again, they complained that the helping professionals showed little interest in talking about their problems” (p. 129; see Phoenix & Kelly, 2013).<sup>9</sup> Sadly, Currie (2004) noted:

No matter how horrific a child’s family history . . . or how thoroughly abandoned she had been by parents or other caretakers, it was unquestionably assumed that it was the *child* who needed to change or to be changed (p. 145).

In the end, the dominant form of intervention demanded that troubled “children ‘take responsibility’ for situations that were, realistically, far beyond their control” as the “conventional helping professions” tended to rely on “some variety of individualistic theory

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<sup>9</sup> Moreover, Currie (2004) reported that “[m]any of the adolescents I spoke with told me their encounters with mental health or treatment professionals had eroded whatever trust they still had in other people” (2004: 170).

about the causes of behavior” (Currie, 2004, pp. 145-148). Ultimately, this “served to individualize and pathologize problems that were invariably more complex and more grounded in social relationships” (Currie, 2004, p. 149; see Conrad and Schneider, 1992). However, rather than acknowledge that “opposition or resistance to authority may have been understandable and perhaps even laudable—even necessary for emotional survival,” mainstream interventions “seemed to equate treatment with the enforcement of obedience” (Currie, 2004, pp. 149-157).

As an antidote to ‘conformist’ intervention, Currie (2013a) advocates that we develop ‘transformative’ intervention that “centers on nurturing the social and political awareness of people who have typically been systematically deprived, neglected and exploited” (p. 9; see Carrington et al., 2014). In addition, it “stresses working collectively with others to change those external conditions.” And it advocates the “fostering of a sense of hope and collective aspiration” (Currie, 2013a, p. 9). While the empowering logic behind ‘transformative’ intervention has a rich history and has occasionally influenced policy (see Cazenave, 2007; Hunter, 1964; Markowitz & Rosner, 2000; O’Conner, 2001; Rothman, 1980), ‘conformist’ intervention is presently ascendant and heavily marketed as evidence-based (see Goddard & Myers, 2013). As beacons of hope, ‘transformative’ interventions have emerged from the ground-up in places like “San Francisco, Seattle, and Los Angeles” (Goddard & Myers, 2013, p. 51). However, because the social structures that drive extreme inequality and social exclusion are still in high gear, Goddard and Myers (2013) suggest that “a transformative critical criminology . . . is needed now more than ever” (p. 59).

Although much of this study contributes to “critical scholarship on treatment and crime prevention,” it also has something “to say about what a more humane alternative might look like” (Goddard & Myers, 2013, p. 54). That is, it offers transformative insights from the frontlines of a

‘conformist’—evidence-based—intervention. Indeed, this study suggests that practitioners of ‘conformist’ interventions may be an untapped resource for ‘transformative’ solutions.

### Mountain View

Located in Small Town USA, Mountain View is an anger management group-home that offers evidence-based treatment for older adolescent males with severe behavioral problems. The residents ranged from 10 to 19 years of age and they were typically diagnosed with multiple disorders such as oppositional defiant disorder, conduct disorder, and attention-deficit-hyperactivity disorder. In general, most of the kids exhibited high levels of anger and aggression and some were occasionally violent.

Within the state, Mountain View was considered a Level B behavioral health group-home; that is, a step-down from a secure institutional placement such as juvenile detention or psychiatric hospitalization. Most of these kids were either on their way out of a secure facility or on their way in. It was our job to make sure that when they left Mountain View they were ready to go back home.

The company that owns Mountain View provides group-home services for impoverished youth as a state contractor. At the time I collected the interviews, ABC was a relatively small company running several group-homes in multiple locations in the region. Although ABC was small, this for-profit provider of Medicaid interventions is indicative of the “marketization of social services” (Myers and Goddard 2013, p. 225; see Bourgois and Schonberg 2009) and the broader “embrace [of] market-driven policies” in the contemporary US (Currie 1997, p. 151; see Garland 2001). Further, as an alternative placement for youth at risk of juvenile justice involvement, this site is also an example of “governing-at-a-distance” (Garland, 2001, p. 127) as

this private organization has been brought into the fold of doing crime prevention work for the state while remaining largely outside of its bureaucratic web.

Like most companies, ABC displays its corporate-self on the Internet. In this display, it uses pastel colors, serene images, and gentle words to convey its noble mission of providing kids with therapeutic, home-like environments. Its treatment is described as evidence-based, individualized, holistic and inclusive of the child's family. Its practitioners are described as having extensive training in behavioral treatment. Further, ABC's integration of behavioral, counseling, and psychotropic interventions is reported to facilitate therapeutic relationships that, in turn, facilitate behavioral change. Ultimately, behavioral change is said to occur through the identification of challenging behaviors that are then replaced when appropriate strategies and alternative behaviors are learned.

As a provider of evidence-based interventions, Mountain View belongs to the category of programs Greenwood (2008) refers to as generic. That is, as a provider of behavioral treatment, Mountain View utilizes a generic type of intervention that has been found to be effective in a variety of formats and in a variety of treatment settings via meta-analysis as opposed to the direct replication of a brand name program (Greenwood, 2008, p. 192). While the evidence supporting generic programs isn't as strong as that supporting brand name—modal—programs, generic behavioral treatment is still touted as an example of “what works” in delinquency prevention (Greenwood 2008, Welsh et al., 2013).

In terms of its structure, Mountain View was usually staffed with one group-home manager, one program coordinator, and approximately ten direct-care workers who split evening, over-night and weekend shifts during the school year. At full capacity, Mountain View housed eight residents and the ratio of residents to direct-care workers was designed to be 3-to-1 for each



shift. The program coordinator worked the day shift and coordinated with the schools the kids went to during the day and the local services they used in the community. The manager—who oversaw the implementation of the program and managed the finances of the home—usually worked a shift that covered half of the day and evening shifts. In addition, a licensed therapist—who was usually off site—was responsible for providing individual, group, and family counseling.

A typical day for the residents of Mountain View consisted of following a program schedule that was primarily run by the direct-care workers. During the school year, the schedule was intended to structure their day from the moment they arrived at Mountain View after school to the time they went to bed. Specific time slots were dedicated to homework, “psychosocial” groups, recreational activities, self-directed activities, meals, chores, and bedtimes. To facilitate the monitoring of the residents and minimize crisis situations, the residents were separated into two groups of three or four kids each. Each group was usually led by a single direct-care worker who was responsible for following the program schedule, keeping the kids within constant supervision, monitoring their self-administration of psychotropic medications, preparing their meals, and teaching them “skills” and “strategies” throughout the shift.

Ultimately, the goal was to teach the residents appropriate ways of behaving when they became angry, defiant, or aggressive. To help facilitate the learning of appropriate skills and strategies, a token economy and a level-system were used to reward positive behaviors. Throughout each shift, direct-care workers were expected to chart the occurrences of skill use, strategy use and challenging behaviors. The ratio of skills and strategies to challenging behaviors were then used to calculate a level score for each shift.

When first admitted, the residents begin at level one, but as their behaviors improve, they can move up to level five, earning new program privileges along the way. The kids were generally considered ready for discharge plans when they were able to maintain at least “level three behaviors” for a few weeks. Although punishments weren’t technically part of the program, the adolescents recognized “time-away” (being sent to their room for a short period of time to contemplate their behavior), and the loss of privileges as punishments. In addition, direct-care workers were trained to physically restrain the kids using Therapeutic Crisis Intervention (TCI) techniques (see Nunno, et al., 2003) when they posed a danger to self and others. The residents tended to see restraints as punishments as well; regardless of how justified they may or may not have been.

### Reflexivity and the Social Justice Paradigm

Before I reveal how slumcare is enabled at places like Mountain View, it is important to be up front about what led to this study and how I collected the data. As a qualitative researcher who uses grounded theory methods, it is important to be transparent about what may have influenced the production of this study (Charmaz, 2014; see Finlay, 2002; Mauthner & Doucet, 2003). Indeed, it is commonly recognized that a researcher’s biography can influence a variety of important choices during the research process such as positions on the nature of reality, the choice of theories that are utilized to make sense of it, and how to ultimately add to the production of knowledge (see Cunliffe, 2003; Hall & Callery, 2001; Meyrick, 2006). In regards to my own biography, I believe it is important for the reader to know that prior to working at Mountain View, I had over six years of experience as a direct-care worker in the behavioral healthcare field and worked in the systems of three different states. Although those systems varied to a degree, poor quality care was not hard to find. While I was accumulating this work

experience, I also pursued a law degree with the hopes of using class action lawsuits to improve the systems of care my clients and countless others were receiving. During the course of an internship with a civil rights law firm in New York City, I learned that governments have a tendency to double-down and defend their policies when they are sued by their citizens. In some of the best-case scenarios, government agencies would reach settlement agreements to change the language of their policies without any indication things were actually going to change in a meaningful way. This frustration with law as a vehicle for reform sensitized me to the various ways that states repeatedly failed their most vulnerable citizens. In addition, it led me to social science and its social justice paradigm.

Within the social sciences, there is a long tradition of using scientific methods to advocate for the most vulnerable and most disadvantaged among us (Burawoy, et al., 2004; Fraser, 1999; Ginwright & Cammarota, 2002; Kiselica & Robinson, 2001; Nussbaum, 2003; Treviño, 2012). In my own field, I have been moved by the wisdom of scholars such as Beth Richie (2011) who proclaimed that criminologists “should prioritize the intellectual work in the discipline that contributes to the creation of a more just society” (p. 212; see Burawoy, et al., 2004, p. 113; Currie, 2013b, pp. 223-229; Delgado & Stefancic, 2001, pp. 3-5, 131-133; hooks, 1994, p. 67; Miller, 2011, p. 3; Richie, 2012, p. 131). Thus, I have paid heed to her call to “explore how organizations, policies, and programme initiatives work to increase or decrease social inequality” (Richie, 2011, p. 213). Further, I view social justice scholarship as that which “takes on a corrective role in responding to . . . social inequality . . . [by] strengthening the social position of those who suffer the most in contemporary society because of structural racism, persistent sexism and exploitation of poor people” (Richie, 2011, p. 213). Moreover, I see “the production of theory as a social practice that can be liberatory” (hooks, 1994, p. 67). Indeed, I

agree with Rios (2011) that “helping people and generating solid empirical research are not mutually exclusive” (p. 16).

However, in the social sciences, it is also well known that individual biases can affect the interpretation of data (Charmaz, 2014). While statistical methods attempt to control for these biases, they generally do not control the biases that influence the researcher’s question, her choice of theories, the measures he decides to use, or the choices she makes regarding how to interpret the statistics (Flyvbjerg, 2006, Sampson, 2010, Young, 2011; see Fiedler, 2011; Podsakoff, et al., 2012, Thyer, 2001). Indeed, numbers can mean very different things depending on which theory is used to interpret them (see Sampson, 2010; Thyer, 2001) and that choice alone can significantly impact lives; especially in criminology and particularly because our work has a long history of influencing policy.<sup>10</sup> Because statistical data are subject to just as much bias and interpretation as any other form of data, it is important for researchers to always reflect on how their life experiences may have influenced their research questions, their choice of theories, and the measures they use. The only question is, is the researcher willing to acknowledge the biases that come with human experience and are they willing to be transparent about how it influenced their study?

One of the reasons why I gravitate towards grounded theory methods and qualitative research in general, is because it asks the researcher to reveal the everyday—taken for granted—biases that can affect our work (Charmaz, 2014; Finlay, 2002; Guillemin & Gillam, 2004; Mauthner & Doucet, 2003). In particular, many qualitative researchers have heeded the call to be reflexive about what drew them to their research question, what experiences might influence how

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<sup>10</sup> As noted by bell hooks, “the privileged act of naming often . . . enables [researchers] to project an interpretation, a definition, a description of their work and actions, that may not be accurate, that may obscure what is really taking place” (hooks, 1994, p. 62).

their questions are framed and how the answers they get are interpreted (see Contreras, 2013; Rios, 2011).<sup>11</sup> If they are studying a vulnerable population, are they being careful not to impose foreign, misguided, or exploitative interpretations? If they are advocating for a vulnerable group, are they centering their voices instead of that of the researcher (Richie, 2012)? If they are fighting for justice, are they clear about what that means to them? Has the researcher been transparent about how “ethically important moments in research practice” were navigated (Guillemin & Gillam, 2004, p. 277)? Although it is often important for the researcher to reflect on how their life experiences influenced their research, reflexivity should be “purposeful, as opposed to defensive or self-indulgent” (Finlay, 2002, p. 542).

With that said, I have gravitated towards the social justice paradigm because of a number of life experiences that are relevant to this study. In particular, it is important to know that as a light-skinned Latino I have experienced both privilege and disadvantage throughout my life because of the different ways I am perceived. My racial ambiguity has not only allowed me to experience both sides of the racial coin, it has also allowed me to cash in on the social capital that comes with being either white enough or brown enough; depending on the situation. At Mountain View, for instance, some of the Native American kids revealed that they saw me as someone who was “brown.” While their assessment of my skin color was never asked for, some of them let it be known that they didn’t see me as white.

Like most Puerto Ricans, I have both African and Native roots. While my jet-black hair, brown skin, and other phenotypical features may have seemed familiar to the kids, it became

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<sup>11</sup> While reflexivity can take on many forms and should be tailored to the specific influences that are relevant to the study, it has been broadly defined as “a process of critical reflection both on the kind of knowledge produced from research and how that knowledge is generated” (Guillemin & Gillam, 2004, p. 274).

clear to me that my comfort with silence and my affinity for non-verbal communication allowed me to develop a bond with them simply by doing little things like pointing to the ketchup bottle instead of saying please first (see BigFoot & Funderburk, 2011; Weaver & White, 1997).

Although some cultures take little things like saying please for granted, it is unnecessary and outside of the norm for other cultures.<sup>12</sup> The behavioral, cultural and phenotypic similarities I had with these kids not only allowed me to develop an effortless bond with them, it also motivated me to unearth some of the key historical factors that led many Native American children to be in places like Mountain View. As someone who was raised to be aware of his Taíno roots, I was sensitized to the brutal legacy of colonization and that connection motivated me to be a zealous advocate for these kids.

In addition, I believe it is important to be transparent about the fact that I was a complete insider prior to being a researcher. That is, when I began working at Mountain View, I had no intentions of studying the program. At the time, I simply saw it as a means of earning additional income while pursuing my graduate studies. This is relevant because my insider status granted me a level of access and trust that might not have been available if I was an outsider observer. In addition, because I shared many of the experiences of my participants and often knew—first-hand—what they were referring to, I believe they were less likely to sanitize those experiences. Indeed, during the course of conducting my interviews it appeared as though many of my participants appreciated the opportunity to vent about those experiences. Further, because some of my participants were friends in addition to colleagues, I believe those interpersonal relationships (see Mauthner & Doucet, 2003) not only provided me with a degree of openness

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<sup>12</sup> Indeed, it is often considered deviant to speak more than necessary in a number of Native American cultures (Weaver & White, 1997).

and honest reflection that may have been difficult to obtain otherwise, it may have also influenced how I presented them in this study.<sup>13</sup>

Further, it is very likely that the institutional context (see Mauthner & Doucet, 2003) affected the data I collected. In particular, when I collected my interviews, ABC was in the early stages of being bought-out by a larger—multistate—behavioral health corporation. Although the design, philosophy, and daily operations of the group-home remained intact during this transition, the administrative structure was in the process of changing. The CEO now had to answer to a board of directors instead of being the sole person in charge. In addition, the regional manager now answered to both the CEO and the clinical director instead of answering directly to the CEO. I believe these shifts in the power structure motivated some of my upper management participants to be more forthright about their frustrations with the previous arrangement. Thus, to the degree that some of the upper management participants revealed significant problems with the program I worked at, it is likely that this was due to the window of opportunity I found myself in as opposed to merely being a reflection of the collegiality we shared and the anonymity I promised them.

Moreover, the summer during which I collected my interviews, Luna had asked the staff she considered to be strong to work longer hours instead of repeatedly hiring new workers to replace weak staff. At Mountain View, those who didn't have what it takes to work effectively with troubled youth were known as weak staff: a theme I will be exploring later. By having her strong staff work longer hours, Luna ensured that at least one reliable worker was present during each shift. Thus, when I collected my interviews, strong staff were overrepresented and weak staff were underrepresented. While this does not take away from the shared experiences of my

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<sup>13</sup> To be fully transparent, I consider Dylan, Luna, and David to be good friends in addition to being colleagues and participants.

participants, it does minimize the voices of those who were generally considered to be weak.<sup>14</sup>

In fact, it is very likely that the findings in the study represent a case of slumcare that is much less severe than what might exist around the country. While Mountain View had a core of strong staff when I collected the data, that core was gone when I left. Further, although the findings of this study speak to disturbing levels of poor quality care, they were significantly worse when new ownership—a national player in the behavioral marketplace—took over.

Lastly, it is without question that my prior work experience in the behavioral health field influenced my interest in this empirical analysis. As someone who worked with impoverished clients for over six years, I was already sensitized to the role that trauma often played in behavioral problems. Further, I already had extensive exposure to those who excelled at this work and those who failed. Moreover, I was all too familiar with the fact that the provision of poor quality care was an issue that crossed state lines. Thus, when I learned that the vast majority of kids at Mountain View were dealing with trauma, but were receiving an intervention that appeared to ignore that trauma, I wanted to know if my colleagues were as concerned about this as I was.<sup>15</sup> Were they tormented about the fact that trauma and the sources of that trauma were not being addressed? How did they experience the quality of care the kids were receiving and did

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<sup>14</sup> Further, I have refrained from identifying the direct-care participants who were considered to be weak staff. I did this for several reasons. First, the identification of weak staff never came up during my interviews. Second, identifying them would not add to the general descriptions of what made weak staff weak. Third, given the possibility that my participants may read this study, I believe that the costs associated with identifying them far outweighed the benefits of putting a name to a well-described practice.

<sup>15</sup> In keeping with grounded theory methods, my research questions evolved as unanticipated themes emerged (Charmaz, 2014; Glaser & Strauss, 1967). Initially, I went into this study wanting to know if my colleagues were concerned about the programmatic silence surrounding trauma. As unanticipated themes emerged—such as the provision of culturally inappropriate care—I began to explore those themes with refined questions.



they have a sense of what accounted for it? While I was hopeful that this study could shed light on some of the concerns I had, I was unaware of the degree to which those concerns were shared.

In many ways, this study is deeply personal. Not only does it conjure the experiences I had as an employee of Mountain View, it also resonates with the six years of experience I had as a direct-care worker in the behavioral health field. Now that I have revealed the factors that may have influenced the data and my motivation to advocate on behalf of the kids at Mountain View, I will now describe how I relied on method to minimize the impact of these influences.

### A Case Study of Poor Quality Care

As a case of poor quality care, Mountain View was ideal to study because my insider status provided me with “ample opportunity for informed, in-depth analysis” (Thomas, 2011, p. 514). To the extent that practitioners’ experiences of poor quality care within evidence-based interventions are not well understood, a case study is ideal because it is often used to generate new theories (Gerring, 2004, p. 350; see Feagin, et al., 1991, Thomas, 2011). In fact, it has been noted that a “virtue of case study research . . . is that it lends itself to theoretical generation and generalization” (Feagin, et al., 1991, p. 13). Although some analysts argue that case-study is a weak method because you cannot generalize from a single case, in-depth case studies have a long and rich tradition of making important contributions to the production of analytic generalizations in sociology as well as other disciplines (see Feagin, et al., 1991, Flyvbjerg, 2006; Gerring, 2004; Riddin, 2006; Thacher, 2006; Verschuren, 2003; Yin, 2014). That is, they have led to the production of important social science concepts and theories, which, according to Becker (1998), “are empirical generalizations, which need to be tested and refined” (p. 128). In fact, the case

study has been defined as “an intensive study of a single unit with an aim to generalize across a larger set of units” (Gerring, 2004, p. 352).<sup>16</sup>

Further, while some analysts argue that a case study involves the study of a “single” case, this is misleading because the number of observations and recorded accounts of the phenomena of interest within that case often amount to a mountain of data (Gerring, 2004; Weiss, 1994). According to Weiss (1994), it is the “welter of details” gleaned from a case study that allow for generalizations (p. 33).<sup>17</sup> Further, case study research not only produces a “wealth of details” that allows for a “nuanced view of reality,” it also allows the researcher to gain numerous “concrete” iterative experiences of the phenomena as well as “feedback from those under study” (Flyvbjerg, 2006, p. 223). Indeed, while the researcher may come into a case study with favorite theories in mind, the constant bombardment of “real-life situations” often forces the researcher to contend with repeated “falsifications” (Flyvbjerg, 2006, p. 235; see Gerring, 2004). As stated by Flyvbjerg (2006), “the researcher who conducts a case study often ends up casting off preconceived notions and theories” (p. 236). Thus, not only is the case study well suited for empirical generalizations, it is also good for demonstrating falsifications of existing theories

While case studies are not designed to test the causal effects of X on Y, they are particularly well suited for identifying “casual mechanisms” (Gerring, 2004, p. 348). Indeed, one of the strengths of an in-depth case study is that the “proximity to reality” (Flyvbjerg, 2006, p. 236; see Feagin, et al., 1991, Ruddin, 2006) allows the researcher to see “what connects the dots”

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<sup>16</sup> While there are a variety of definitions for what a case study is, it has been noted that “what unites them is a commitment to studying the complexity that is involved in real situations” (Thomas, 2011, p. 512, citing Simons, 2009).

<sup>17</sup> Similarly, Feagin, et al. (1991), state that the “detailed and rich data offered by the well-crafted case study permit the analyst to develop a solid empirical basis for specific concepts and generalizations” (p. 7).

(Gerring, 2004, p. 349).<sup>18</sup> In addition, causal connections are often “rendered visible once one has examined the motivations of the actors involved” (Gerring, 2004, p. 348). As noted by Feagin, et al., (1991), case studies allow the researcher to “see human beings up close, get a sense of what drives them, and develop claims of how their personal as well as collective lives have been created” (p. 11). However, because the social sciences have recently been dominated by large N analyses that are far removed from the phenomena they study, it has been argued that “there is a need for “a greater number of good case studies” (Flyvbjerg, 2006, p. 242). Indeed, it has been argued that the social sciences are in need of new theories (see Bernard, 1990; Kellner, 1993; Miyaji, 2002; Russell, 1992; Young, 2011).

#### Grounded Theory for Realists

Although there are a variety of methods one could use to generate theories from a case study (Burawoy, 1998; Burawoy, 2003; Charmaz, 2001; Glaser & Strauss, 1967; Smith, 2005), I chose grounded theory (Charmaz, 2014; Glaser & Strauss, 1967) because of its compatibility with critical realism (Oliver, 2012; Yeung, 1997). While critical realism has been referred to as a “philosophy in search of a method” (Yeung, 1997, p. 55), grounded theory methods have been described as highly compatible with the critical realist goal of producing “explanatory theory” (Oliver, 2012, p. 383; see Bhaskar, 1989) and its call to search for “causal mechanisms in concrete phenomena” (Yeung, 1997, p. 62).

A central premise of critical realism—which resonates with my own experience—is that “there *is* a reality out there” that can be experienced, that exists independent of our experiences, and is influenced by generative mechanisms (Houston, 2001, p. 850; see Bhaskar, 1989).

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<sup>18</sup> According to Feagin, et al. (1991), “a principle argument for case study research is that it provides a way of studying human events and actions in their natural surroundings” (p. 7). Indeed, the hallmark of a good case study is that it “usually brings us closer to real human beings and everyday life” (p. 23).

However, according to critical realism, social phenomena are qualitatively different from natural phenomena and therefore require different methods of analysis (Bhaskar, 1989). Although the laws governing gravity, the speed of light, and cellular structures are universal constants, the laws governing social structures have an unpredictable shelf-life because—unlike gravitational forces—they can suddenly change direction, disappear, or simply lose their power. From a realist perspective, social structures “may be only relatively enduring” because of the interplay of multiple factors such as the historical, the local, and our capacity to change them (Bhaskar, 1989, p. 38, 128-129).

Indeed, because agency—among other things—matters within a critical realist perspective, it is presumed that “[o]ur actions are influenced but not determined by social structures” (Oliver, 2012, p. 381).<sup>19</sup> According to this view, social structures are “in principle enabling, not just coercive” (Bhaskar, 1989, pp. 36-40). While “social structures” can be “just as ‘coercive’ as natural laws,” Bhaskar (1989) argues that social structures “would not exist” if individuals did not “reproduce or transform” them (p. 20, 36).<sup>20</sup> Thus, according to critical realism, the essential nature of “social reality” is to be found “between agency and structure” (Oliver, 2012, p. 381).<sup>21</sup> The objective for social scientists—according to this realist view—is to “lay out the structural conditions for various forms of conscious human action” (Bhaskar, 1989,

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<sup>19</sup> In fact, critical realism assumes that the mechanisms governing social phenomena are “neither determinative nor all-explaining” (Oliver, 2012, p. 374).

<sup>20</sup> According to Houston (2001), “Bhaskar acknowledges the constructivist’s insight that people can transform their everyday worlds and yet, the theory provides a more adequate account of social life by also acknowledging the role of structural factors” (p. 851).

<sup>21</sup> According to critical realism, neither structure nor agency can be reduced to the other. That is, “[s]ociety is only present in human action, but human action always expresses and utilizes some or other social form” (Bhaskar, 1989, p. 37). Indeed, social structure and agency are presumed to have a duality. According to Bhaskar (1989) “[s]ociety is both the ever-present *condition* (material cause) and the continually reproduced *outcome* of human agency. And praxis is both work, that is, conscious *production*, and (normally unconscious) *reproduction* of the conditions of production, that is society” (pp. 34-35).

p. 36). A “critical realist methodology must therefore have the dual focus on agency and structure, the individual and wider society” (Oliver, 2012, p. 381).<sup>22</sup>

According to this realist perspective, the relationships between “positioned-practices” in society are good places to investigate “the ‘point of contact’ between human agency and social structures” (Bhaskar, 1989, pp. 40-41). In that regard, grounded theory methods are ideal because they allow the researcher to trace “individual action to reasons to rules to structures” (Oliver, 2012, p. 382). Not only is the method ideal for “grounding abstract causal mechanisms in empirical data” (Yeung, 1997, p. 63), it also calls on the researcher to theoretically sample “[s]tructural conditions like policy and service provision” (Oliver, 2012, p. 382) in practices such as behavioral healthcare.

While “[c]ritical realism presupposes an objective reality which exists independently of our thoughts and whose discovery is one purpose of knowledge acquisition . . . it also holds that all description of that reality is mediated through the filters of language, meaning-making and social context” (Oliver, 2012, p. 374).<sup>23</sup> However, rather than assuming that meaning is all that matters, critical realism proposes that “knowledge (or description) of objects are not the same as (and do not determine) the conditions of the possibility of these objects” (Bhaskar, 1989, p. 142). To suggest that knowledge of an object is equivalent to the essence of that object is to engage in an “epistemic fallacy” (Yeung, 1997, p. 53; see Bhaskar, 1989). Indeed, the meaning that actors give to their actions may actually “*mask* . . . the nature of the activity” (Bhaskar, 1989, p. 136). Thus, while a constructivist grounded theorist would focus primarily on narrative and meaning-

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<sup>22</sup> Similarly, Mills (1959) remarked that “[n]either the life of an individual nor the history of a society can be understood without understanding both” (p. 3).

<sup>23</sup> In that regard, critical realism has been described as a perspective that “marries the positivist’s search for evidence of a reality external to human consciousness with the insistence that all meaning to be made of that reality is socially constructed” (Oliver, 2012, p. 372).

making (Charmaz, 2014, pp. 9-13; see Berger & Luckmann, 1966),<sup>24</sup> the realist grounded theorist would presume that narratives “do not exhaust social reality, but rather . . . stand in need (in principal) of social explanation” (Bhaskar, 1989, p. 138).<sup>25</sup> According to this realist lens, “the limits of language are not the limits of the world” (Bhaskar, 1989, p. 142). In fact, one of the primary goals of critical realism is to unmask and expose false consciousness (Bhaskar, 1989; Yeung, 1997).<sup>26</sup> It has been argued that by examining “underlying social structures, critical realists may contribute towards the eventual freedom of social actors from the imprisonment of false consciousness” (Yeung, 1997, p. 63). In that regard, realist grounded theory would “pursue emancipatory, rather than merely descriptive goals” (Oliver, 2012, p. 378).<sup>27</sup>

## Methods

In this study, I initially wanted to know if my colleagues were concerned about what I perceived to be a haunting silence surrounding the trauma most of the kids were dealing with at Mountain View. To examine how they experienced their work, I conducted semi-structured, in-depth interviews with the practitioners of Mountain View and the upper management of ABC

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<sup>24</sup> Rather than assuming that social phenomena represent an “objective external reality” that is made up of discoverable structures, the constructivist approach assumes that “process, not structure” is the heart of the social and that we constantly create, recreate, and transform structures by “engaging in processes” (Charmaz, 2014, pp. 9-13; see Berger & Luckmann, 1966). Thus, the constructivist approach places “emphases on examining processes, making the study of action central, and creating abstract interpretative understandings of the data” (Charmaz, 2014, p.16).

<sup>25</sup> Indeed, “[c]ritical realist grounded theorists” would go beyond what participants say and “examine the structural roots of contradictions between what is said and unsaid . . . between appearance and deeper structure” (Oliver, 2012, p. 382).

<sup>26</sup> On that note, Mills (1959) argues that the “sociological imagination . . . enables [a person] to take into account how individuals, in the welter of their daily experience, often become falsely conscious of their social positions” (p. 5).

<sup>27</sup> Although Bhaskar (1989) acknowledges that “all beliefs are socially produced,” it is not the case that all beliefs are equally valid (pp. 57-59). Ultimately, some descriptions have more explanatory power than others and according to critical realism, a “powerful explanatory theory” is that which can “explain false consciousness” via “non-deterministic” propositions (Bhaskar, 1989, pp. 59-64).

(see Charmaz, 2014, pp. 55-108; Yin, 2014, pp. 110-112; Noaks & Wincup, 2004, pp. 74-87; Weiss, 1994, pp. 207-208).<sup>28</sup> At the time I collected the interviews, Mountain View was running on minimal staff. To increase the number of participants, I recruited two former colleagues through a participant who was a mutual friend. In total, I interviewed eight direct-care workers and five upper management participants.

As a method, in-depth interviews are considered ideal for developing grounded theory because they facilitate an “open-ended, in-depth exploration of an area in which the interviewee has substantial experience” (Charmaz, 2014, p. 85). Indeed, the method allows the researcher “to start from where people are at” and “enable them to share their experiences . . . meanings and understandings” (Noaks & Wincup, 2004, pp. 75-76). When an organization is the focus of study, it is argued that because they involve “people in well-defined roles,” in-depth interviews should be conducted with “people in different jobs on different levels, in different relationships to the institution, and from different informal groups ” (Weiss, 1994, p. 19; see Powell & DiMaggio, 1991; Smith, 2005).

By interviewing participants in key positions such as the group-home manager, the regional director, and the CEO, I was able to gather key insights about how ABC was structured, how larger structures affected the company and how ABC oversaw the operations of Mountain View. While interviews are not natural forms of interaction, I utilized the open-ended format to

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<sup>28</sup> Following institutional review board approved protocols, I utilized an interview guide that allowed for follow up questions when unanticipated themes emerged. The interviews ranged from approximately 1 to 2 hours and were transcribed by me to gain “intimate familiarity” (see Charmaz, 2008, p. 162) with the data. Although I already had deep familiarity with the phenomena I was studying, I wanted to immerse myself in my participants’ descriptions of the shared realities they faced. During the transcription process, I made note of key emotive moments and contemplative pauses during the interviews when it was clear that they conveyed meaning. Indeed, key pieces of data could easily have been interpreted to mean something completely differently if the tone (sarcasm, for instance) was not captured in the transcript.

engage my participants in conversations about the work experiences that mattered to them. That is, I gave my participants space to discuss tangents that were meaningful to them and I encouraged them to tell the stories they wanted to share.

To minimize the effect of preconceived theories,<sup>29</sup> I utilized an interview guide with general open-ended questions about the work experiences of my participants—as opposed to my theoretical interests—and refrained from asking questions about the kids’ trauma and what I perceived to be the narrowness of the program. Consistent with critical realism and the original conceptualization of grounded theory, I waited to see if these themes emerged on their own as my colleagues described their “positioned-practices” (Bhaskar, 1989, pp. 37-41, see Glaser & Strauss, 1967). When these themes did emerge, I then asked follow up questions. In keeping with theoretical sampling (see Charmaz, 2014; Glaser & Strauss, 1967), I also followed the lead of unanticipated themes in subsequent interviews.

Following the guidance of Glaser and Strauss (1967) and Charmaz (2014), I coded the interviews line-by-line for types of experiences; focusing on the kinds of practices, insights and structures they were describing. To discover common themes, interviews were read multiple times and coded pieces of data were constantly compared to find where they converged. Data that didn’t fit with a concept after repeated scrutiny was removed from that concept (see Glaser & Strauss, 1967, p. 3). When those removed pieces of data were reanalyzed in the larger context of what was being said in the interview, important variations often revealed that those experiences were similar but different in a meaningful ways. When it was discovered that those nuanced experiences were shared by others, new concepts were then formed. Memo-writing was

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<sup>29</sup> As an initial theoretical framework, I went into this study ready to explore the medicalization of deviance (Conrad & Schneider, 1992) and its role in individualizing child maltreatment and I was prepared to study the interrelations of power and knowledge in the disciplinary techniques (Foucault, 1977) of the group-home.



then used to explain how the emergent concepts were connected and related. When constructed frameworks were examined for inconsistencies and the inability to fully account for the shared experiences in the data, they were either rebuilt or discarded.<sup>30</sup>

Throughout the research process, emergent concepts were also constantly compared to the literature and other theoretical accounts to examine how the emerging theory “extends, transcends, or challenges dominant ideas in [the] field” (Charmaz, 2014: 305). In particular, I conducted literature reviews on evidence-based interventions, therapeutic relationships, crisis management, culturally appropriate interventions, the privatization of crime control, the failures of Medicaid managed-care, collective trauma, and more.

True to grounded theory methods, I also developed new questions as the analysis progressed. For example, when the data pointed to some of the extreme discrepancies between the rhetoric of ABC’s program documents and the reality of what it was like at Mountain View, I wanted to understand how practitioners made sense of the discrepancies they faced. In addition, when the data revealed that larger structures were implicated in slumcare, I wanted to know how they were experienced and how they might be implicated. Because poor quality care could—and arguably should—inspire reform, I wanted to know how it persists and how my colleagues make sense of its persistence? Further, how do they manage it and how do they attempt to complete the mission of the organization? In what ways does the model of the program interfere with the provision of quality care? Moreover, I wanted to know what led to the disproportionate number

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<sup>30</sup> Consistent with critical realism, concepts were constantly refined to achieve maximum explanatory power (Bhaskar, 1989). Further, as an attempt to achieve the most adequate explanation possible, it is presumed that these constructed understandings are not to be viewed as the equivalent of the social phenomena they are attempting to explain. Similarly, Glaser and Strauss (1967) notes that grounded theory should be viewed as an “ever-developing entity, not as a perfected product” (p. 32).

of Native American youth at Mountain View? How did my Native American friends and colleagues experience the program and its interventions? How might these services be improved?

As my research questions developed, additional sources of data were theoretically sampled to facilitate the generation of a theory (see Charmaz, 2014; Glaser & Strauss, 1967). In particular, organizational documents I was given access to and the company's website were analyzed via coding and the constant comparative method. In addition, literature on the history of Medicaid managed-care, the history of TCI, and the history of collective trauma were also sampled to fill in gaps in the analysis. Moreover, literature on evidence-based interventions, culturally appropriate interventions, and therapeutic relationships were also sampled to understand the philosophy, rhetoric and effectiveness of these practices and how they are linked to larger structures.

By using the constant comparative method as intended, I prolonged the analysis of this study for a number of years until a theory emerged from the repeated comparison of emergent concepts to the experiences they were intended to unearth and to the pre-existing literature. Indeed, grounded theory methods are both time-consuming and rigorous. Although these methods generally result in a "delayed" research process, it can lead to the production of theoretical frameworks that not only account for the experiences of those in the study, but are also relevant to the lives of similarly situated individuals (Glaser, 1978, pp. 16-25; see Glaser & Strauss, 1967).<sup>31</sup>

Similar to Contreras (2013), this study is largely grounded in the shared experiences of friends, acquaintances, and people I barely knew. To avoid what he calls "cowboy"

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<sup>31</sup> Since the concept of slumcare emerged, conversations with a number of social service practitioners over the years have revealed that the term "slumcare" resonates with their experiences. This informal confirmation encouraged me to keep the term as it appeared to be relevant to practitioners.

ethnography—ethnographic research that exploits participants for the glory of the researcher (p. 26)—I decentered myself from most of the analysis and focused—instead—on the shared experiences of my participants. Although I have allowed my experiences to enter into the discussion when narrating key points, I have generally limited that to experiences that were shared with others. In addition, I have included ethnographic data to triangulate key events and to demonstrate how I experienced Mountain View at the time.<sup>32</sup> Further, instead of telling you that my colleagues shared similar experiences, I decided to showcase their stories of what this work was like throughout most of the chapters so the reader can actually see how they were shared. Moreover, I have minimized the use of heavy-handed jargon in an attempt to produce a theory that can be understood by practitioners, advocates and community activists, in addition to academics. As noted by hooks, “any theory that cannot be shared in everyday conversation cannot be used to educate the public” (hooks, 1994, p. 64; see Burawoy, 2005; Currie, 2007; Jenness, 2008).

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<sup>32</sup> Reflexively, I stated in my first journal entry on 8/8/08 “[a]lthough I am officially beginning my [research] with this first entry, my ‘master status’ is that of worker. These thoughts mostly reflect my disgust as someone who has seen the inner workings of the home I work at.” Thus, the reader should keep in mind that my journal entries reflect the thoughts of a complete insider who was distraught by what was taking place at Mountain View.

## Organized Chaos: Tales of Unsustainable Care

Alex looked the part of a young CEO: his oxford shirt was crisp, his khakis were boardroom-appropriate, and his smile was polished. When I interviewed my boss, I expected him to be guarded, if not defensive (Journal Notes). This was his company I was scrutinizing and I was a mere subordinate. As we sat down to drink our coffee, it became clear—however—that he relished this opportunity to talk about ABC. When I asked him if I had permission to record our conversation, he replied: “Absolutely, yes.”

Sitting outside of a coffee shop in Small Town, Alex decided the best way to answer my first series of questions was to give me “a little history” of what brought him to this moment. When he was a nineteen-year-old Anthropology major at a large university in Capital City, Alex “took a class in Psychology” which peaked his interest. After a fateful meeting with his professor about career options in 1989, Alex pursued a position at a group-home where he “fell in love with the field.”

As a mid-October breeze animated the steam from his coffee, Alex admitted he “knew nothing about behavioral health at the time,” but “by the year 2000 . . . pretty much held every position within the company.” Later that year—while in the position of “residential director”—a state behavioral health agency “sent out a letter saying that there was a need in [Small Town].” Alex was “excited” about the news because he was beginning to have “major philosophical differences” with his employer. As he explained it, “we were purchased by another larger

corporation that didn't necessarily have the same philosophy of treatment that we did." That is, "[i]t was more about census—you know—making money . . . [and] I think quality of care really declined at that point." Ultimately, Alex saw the need in Small Town as an exciting opportunity to start a new company that would "stay small, be more involved with daily operations . . . [and] have greater control over the quality of care that the kids were receiving." In other words, Alex was on a mission to balance the provision of care with the pursuit of profit.

As he told me his story, I found myself captivated by an image of Alex I never had before. In my research journal I wrote that prior to the interview "I must admit, that I saw him as a business man who just happened to get involved in the behavioral health field. I went into the interview expecting to hear the perspective of a businessman who had little connection to behavioral health or to the kids directly" (Journal Notes). The more we talked, the more I realized his title and position of power were bolstered by experiences in the trenches. Although I knew Alex was a CEO with an MBA, I wasn't aware he was once a frontline worker like myself. Indeed, Alex presented himself as someone who was guided by his insights as a former direct-care worker.<sup>33</sup>

Consistent with his vision of care, the company that Alex built proudly advertises that it delivers a proven commodity. In particular, meta-analytic studies have demonstrated that the behavioral treatment ABC offers is effective and considered to be evidence-based (Greenwood, 2008; Lipsey & Howell, 2012). These studies not only show that behavioral approaches achieve better results than traditional therapy; they also show they can achieve success in different settings. Although the effectiveness of group-homes as sites of intervention is debated, those

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<sup>33</sup> In addition, I wrote in my research journal "[w]hen the interview was over, I saw him as someone who had nothing but good intentions when he started this company. He genuinely wanted to help these kids and genuinely wants to improve the company" (Journal Notes).

with behavioral approaches have been found to achieve significantly better results (DeSwart et al., 2012; James, 2011; Knorth, et al., 2008; Larzelere, et al., 2001; Larzelere, et al., 2004; McCurdy & McIntyre, 2004; Scott & Lorenc, 2007; Sinclair, et al., 1995). Thus, Alex’s commitment to quality care seems to be evident in the behavioral design of the program.

However, the evidence isn’t as clear-cut as many think it is. The studies that show that some types of treatment are superior to others also show there is variability in their effectiveness (see Lipsey and Cullen, 2007). Indeed, in some cases even the most heralded interventions—such as the Blueprint Programs—achieve underwhelming results in practice. Thus, it has been concluded that “[f]actors other than the type of treatment . . . must be influencing the effects” of programs (Lipsey and Cullen, 2007, p. 307). In fact, it has been argued that “no programs or program types have been identified that consistently produce positive effects” (p. 309). Although the science that supports evidence-based interventions is encouraging, it is evident that these programs are not “magic bullets” (p. 310).

In an effort to unpack the secrets to effective treatment, it has been argued that “[u]nderstanding . . . process factors within interventions . . . is an important adjunct to the focus on . . . evidence-based practices” (Southerland, et. al., 2009, p. 50). In particular, mounting evidence suggests that therapy process variables—such as the quality of the therapeutic relationship—might be very important (Karver, et al., 2008; Kazdin, et al., 2006; Zack, et al., 2007). As a clinician in one study stated ‘[y]ou have to build that relationship before they’ll listen to anything else you say that might be evidence based’ (Nelson, et al., 2006, p. 403).

While Alex may have been dedicated to offering a quality program backed by science, the vision of care he spoke of was not evident in the conversations I had with our fellow colleagues. In particular, I will show how the providers of this evidence-based program were

often of questionable quality. Although ABC occasionally hired direct-care workers who appeared to have a natural ability to develop therapeutic relationships, recruiting them was a crapshoot and retaining them was nearly impossible. Instead of maintaining high quality care within a smaller for-profit context, the conversations I had revealed that youth were constantly exposed to practitioners who not only failed to establish therapeutic relationships with troubled kids, but actually facilitated chaos.

In this Chapter, I will review the science that shows that quality therapeutic relationships matter within evidence-based practices. In addition, I will show how there are gaps in our understanding of how therapeutic relationships develop in group-care settings; especially in regards to the “array of relationships” youth are exposed to in these out-of-home placements (Florsheim, et al., 2000, p. 96). In an effort to help fill these gaps in understanding, I will reveal how some practitioners—known as “naturals”—developed therapeutic relationships at Mountain View while others—known as “weak staff”—facilitated chaos. Tragically, I will then reveal how the state enabled “organized chaos” at Mountain View.

### Therapeutic Relationships

In the psychological literature, it is well accepted that the connection between a therapist and a client is of vital importance for treatment. In fact, studies have demonstrated that the quality of the therapeutic alliance<sup>34</sup> is associated with treatment outcomes (Karver, et al., 2008; Kazdin, et al., 2006; Zack, et al., 2007). Further, it has been shown that even evidence-based programs vary depending on the quality of therapeutic relationships (Southerland et al., 2009). Indeed, the therapeutic relationship is regarded as a “proven . . . transtheoretical process . . . associated with treatment outcome across a diverse range of treatment models” (Hogue and

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<sup>34</sup> In the literature, the terms therapeutic relationship and therapeutic alliance are often used interchangeably.

Liddle, 2009, p. 137). Regrettably, however, it has been noted that the evidence-based practice “movement has largely ignored more universal aspects of the therapeutic process that may be of even greater importance to treatment outcomes” than types of treatment (Karver, et al., 2006, pp. 50-51). As a common factor across treatments, it is very likely that the therapeutic relationship is key to most—if not all—psychotherapeutic interventions.

Although the adult psychotherapy literature has shed light on the importance of the therapeutic relationship, the construct has received considerably less attention in youth psychotherapy research (Zack, et al., 2007). However, the research that does exist indicates that quality therapeutic alliances with youth are important for successful treatment outcomes.<sup>35</sup> For example, Karver et al. (2008) found that this connection was strongly associated with client involvement in treatment “irrespective of treatment approach” (2008: 22). In a study by Kazdin et al. (2006), it was found that higher quality therapeutic relationships were significantly related to improvement for adolescents receiving cognitive problem-solving skills training: an evidence-based practice for oppositional, aggressive, and antisocial behaviors. Similarly, Southerland et al. (2009) found that quality therapeutic relationships in Therapeutic Foster Care—a “widely disseminated evidence-based practice”—were “significantly associated with better emotional and behavioral functioning” (p. 50, 59). Given their findings, the authors noted that the features of the program were “necessary but not sufficient” for improved functioning (pp. 59-60).

While this growing body of research suggests that quality therapeutic relationships are important for youth, most of this research has focused on outpatient settings (see Hurley, et al., 2013). Indeed, it has been noted that there has been “minimal research” examining therapeutic

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<sup>35</sup> In a meta-analysis of 49 studies, the authors noted that the therapeutic relationship is “among the most robust predictors of treatment outcomes” (Karver, et al., 2006, p. 51).



relationships in out-of-home placements such as group-homes (p. 56; see Florsheim, et al., 2000; Harder, et al., 2012; Manso, et al., 2008; Southerland, et al., 2009). Given the “sheer quantity of time” group-care clients spend with their caregivers and the importance placed “on the effect of the ‘milieu’” in their treatment, it has been argued that the importance of quality therapeutic relationships in these settings is vital (Zegers, et al., 2006, p. 325). However, therapeutic relationships in group-care settings are likely to be more complex as youth are exposed to an “array of relationships” with program staff as opposed to a singular relationship with a therapist (Florsheim, et al., 2000, p. 96).

For example, in one study of delinquent males in group-care settings, it was found that youth who developed a positive therapeutic relationship with a direct-care worker were “more likely to have made significant therapeutic gains and less likely to recidivate” after one year (Florsheim, et al., 2000, p. 104). However, this study failed to explore the complexities involved in the “array of alliances” as it narrowed its focus to “a single staff-youth relationship” selected by the adolescent for the study (p. 97).<sup>36</sup>

In addition, it has been noted that there is a need to examine the factors that facilitate the development of a therapeutic relationship (Florsheim, et al., 2000; Southerland, et al., 2009). In a qualitative study of a wilderness residential program, youth identified caring, trustworthiness, maturity, and self-awareness as qualities that facilitated therapeutic relationships with their teacher-counselors (Manso, et al., 2008). In addition, these practitioners listened to youth, were committed to them, held them accountable and were respectful. Moreover, when these youth

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<sup>36</sup> Similarly, Zegers et al. (2006) focused on individual mentor-client relationships within a group-care setting in the Netherlands. In this study, it was found that “attachment representations” of the adolescents predicted reliance on their mentor and the quality of contact with their mentor (p. 331). Again, however, the complexities involved in the multitude of relationships these youth are exposed to was neglected in this study and it was noted that future research should explore the quality of all the “relationships” in their group-care “networks.”

identified the qualities and behaviors that facilitated therapeutic relationships, they “focused more on personal traits rather than professional skills” (pp. 67-68). In a quantitative study of a secure residential treatment center in the Netherlands, it was found that youth identified “treatment skills” such as reliability, clarity, and commitment as being important for the development of quality therapeutic relationships (Harder et al., 2012, pp. 10-11). However, both of these studies focused on the relationships these youth had with only one direct-care worker as opposed to the network of relationships that are typical in group-care settings.

Despite the growth of research in this area, our understanding of how therapeutic relationships develop in practice is still shrouded in mystery and subject to much debate (see Zack, et al., 2007). While research consistently points to a collage of skills and attributes that are needed to establish therapeutic relationships—such as being trustworthy, reliable, committed and caring—we don’t know much about how, why—or even how often—therapeutic relationships fail to be established within evidence-based—group-care—settings. In the remainder of this chapter, I will show that—while some staff understood what it took to establish therapeutic relationships at Mountain View—the provision of those relationships were sporadic, unsustainable and often chaotic. In the following pages, I will unpack what works in developing therapeutic relationships in this group-care setting, describe the array of relationships youth were exposed to at Mountain View and reveal why organized chaos was the norm.

### Naturals

When I interviewed my colleagues at Mountain View, I asked them about the skills that were needed to work effectively with the residents. In the process of discussing what it takes, it was often—and widely—recognized that these skills were in short order and that most people didn’t have them. Indeed, the interpersonal skills that were needed to be successful at Mountain

View were extremely uncommon. At Mountain View, those who had the necessary skills were known as *naturals*.

According to Lance—the newest direct-care worker I talked to—“it definitely takes a special person to do this kind of work.” Krystal, who was the youngest direct-care worker, reported that “the job isn’t for just anybody.” Indeed, in her experience “a lot of people . . . failed.” Similarly, Luna—the group-home manager—told me “the job is for some people and it’s not for others.” In Charlie’s experience, even if a direct-care worker was properly trained, “it still takes . . . the right person.” According to Alex, “you have to have the right person in this position.”

In practice, those who had the right stuff were experienced as being “naturals.” According to Tina—the regional manager—“I think some have a natural born ability to . . . just to know how to talk to a kid or how to make them feel a little bit more comfortable or safe.” When I asked Daisy—the group-home therapist—if the requisite skills could be trained, she replied “[s]ome people have that by nature. They’re just very calm . . . But, not all staff are.” In Alex’s experience, “I think we have a lot of people that are just naturals in the field.”

However, finding and recruiting naturals was not easy. In order to recruit the right people Alex stated “what we’re looking for is somebody who cares about the kids.” When I asked Alex “how do you measure that, how do you recruit that?”, he replied “the caring? You can’t. I mean (laughing) . . . It’s rolling the dice.” Although his company utilized “a lot of scenarios” during the interview process “to solicit . . . their level of caring,” Alex stated “it’s hard” because “[p]eople are going to say the right things.” Thus, despite attempts to recruit the right people, ABC nevertheless had a practice of granting unwarranted authority to direct-care workers who would “say the right things” even though they had neither the ability, nor the skills, nor the interest in

working effectively with troubled youth. Although it would be a stretch to say that ABC knowingly gambled with lives of its residents, it's clear that its hiring process involved a substantial amount of risk.

While it is commendable that ABC sought to solicit an appropriate “level of caring,” my participants in this study revealed that caring—although necessary—was far from sufficient. According to ABC's staff, troubled youth benefited the most from practitioners who could establish *natural connections*, who had *emotional grit*, and who could provide youth with *consistent care*.

### Natural Connections

Central to ABC's treatment philosophy is the development of therapeutic relationships between the direct-care workers and the group-home residents. According to company documents, successful rehabilitation hinges on the development of these relationships as direct-care workers are viewed as the *primary change agents*. Thus, when Alex told me “I think the majority of change occurs in the milieu and it occurs with the direct-care staff; it occurs with the relationships that are built between the staff and the client and without that relationship, nothing else occurs,” he was being entirely consistent with this philosophy.

However, Alex did not appear to be reciting a mere script in keeping with ABC's mission. As he told me about the importance of therapeutic relationships at ABC, it was clear he was espousing a conviction rooted in experience. For example, when Alex told me what it took to be an effective direct-care worker, he stated “yeah, it's all about relationships. I really believe that. If you can't do that, then you shouldn't be with us.” He added, “I think that's where you have to have the right person in this position. I'm not saying that [you] can't create a system for it, but it's hard to develop a canned approach in developing relationships. There's things that we can

(pause)... you know, we set up different opportunities, scenarios to encourage interaction but you got to be able to form relationships first, before you can really implement a system properly. So, that's tough. We've tried to do that.”

Although therapeutic relationships are central to ABC's treatment philosophy, Alex revealed that his company struggled with how to facilitate their development. While he hasn't relinquished the idea that a system could be created for facilitating them, in his experience it was clear that “you have to have the right set of individuals.”

When I talked to my colleagues at Mountain View, it became evident that what enabled naturals to work effectively with troubled youth was their ability to establish *natural connections*. Instead of utilizing a formal practitioner-client dynamic to develop an affective bond, naturals utilized *unforced interactions*, driven by *reliable care*, to facilitate *natural points of connection* that resonated with the lives of adolescents. As reported by Luna—the group-home manager—“there was a connection there that—you know—only somebody in our line of work could actually experience and establish with those boys.” While it may be true that on-the-ground experience is necessary to fully understand how natural connections with youth are established in group-homes such as Mountain View, it is my hope that by unpacking the similarly shared experiences of direct-care workers, I can help to facilitate a much richer understanding of how these connections are established in practice and why they are nearly impossible to sustain.

### *Unforced Interactions*

At Mountain View, it was commonly understood that effective interactions with youth were based on intuitive interpersonal skills and could not be forced.<sup>37</sup> For instance, when I asked

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<sup>37</sup> Although the residents of Mountain View had no choice in their placement and had no choice but to be exposed to the group-home staff, they did pick and choose who they would get along with, gravitate towards and trust.

David if the job required any special skills, he stated “people skills, definitely people skills.” Echoing this sentiment, Luna told me direct-care workers “should have some knowledge in people skills.” When I asked Luna if education mattered, she replied that in her experience there were “some direct-care staff that were outstanding [and] didn’t have degrees . . . I think a lot of it is intuitive and I think a lot of it comes from that person.” In Dylan’s experience, “[i]t depends on who you are. I would say I would be able to talk to a lot of the kids at the time and be able to do some sort of intervention.” Jimmy reported, “first of all, you got to be able to work with kids.” While the ability to “talk to” kids and “work with” them was seen as necessary, it was also experienced as a skill that flowed from the person in an intuitive and unforced manner.

In fact, it was also common for ABC’s practitioners to note that the connections established between the residents and direct-care workers were often stronger than that with the master’s level therapist. When I asked Tina why that might be, she replied “human connection. I don’t know what’s behind that.” Although the alchemy of “human connection” remained a mystery to Tina, it was clear that advanced education did not supply the necessary elements. When I asked Tina if the ability to establish connections with youth could be taught or trained, she responded “yeah, yeah, I honestly believe that. The question is how?” In regards to the training ABC provided, Lance reported:

Even with all those skills—if you have those—you still have to know how to work with people too. Some people can have all those skills, but if they don’t know how to work with someone and know how to work with them at their level then they’re not going to get very far. They’re not going to really reach these kids. They’re just gonna kind of stay at the surface level. Definitely having someone

that has the skills to be able to work with the kids on a deeper level really helps in the rehabilitation process, I think.

Although Lance acknowledged that his behavioral training was helpful, on-the-job-experience led him to believe that the interventions direct-care workers were taught were insufficient. Without the ability to connect and reach the kids at their level, efforts at rehabilitation would not go very far. Similarly, when I asked Gary—the trainer—if direct-care workers needed to have special skills, he replied “being able to deal with each kid, or each resident, according to their level of functioning.” Thus, in Gary’s experience, instead of forcing upon youth a generic style of interaction, effective direct-care workers dealt with the kids as individuals and related to them according to their unique levels of development and ability.

Among Mountain View’s practitioners, it was commonly understood that some people had the “people skills” needed to intervene with troubled youth and others did not. Even if you had all the training ABC provided, behavioral interventions with youth were doomed to fail if you didn’t have the ability to “reach” these kids as individuals.<sup>38</sup>

In addition, it was also commonly recognized that connecting with youth wasn’t a one-way street. Even if a direct-care worker was known for having strong “people skills,” there was no guarantee a particular kid was going to like that particular direct-care worker. Thus, while “people skills” were necessary for reaching youth, they weren’t sufficient. As disclosed by Tina:

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<sup>38</sup> In this regard, the practitioners of Mountain View indicate that although they are trained to be “technicians of behaviour” (Foucault, 1977, p. 294), the disciplinary techniques they are taught are insufficient for addressing behavioral problems. Indeed, while Foucault (1977) argues that disciplinary techniques produce a ‘soul’—that is, “the inclinations” within an individual (p. 16; 295)—my colleagues indicate that the soul cannot be reached without interpersonal techniques. However, because my colleagues were committed to the mission of behavioral correction, the use of these interpersonal techniques can be seen as “contained secondary adjustments” (Goffman, 1961, pp. 199-200). That is, they utilized “unauthorized means” to achieve the correctional goals of the institution (see Goffman, 1961, p. 189).

I've been in the field for a long time and I've watched certain people's personalities will set certain kids off. They don't want anything to do with them: remind them of somebody in their past; somebody who has abused and hurt them, or just mistreated them, or that they didn't feel close to, and they'll register that, and you may not be that way, but if they register you that [way](pause)... forget it, you won't get anywhere with the kid, but then it's almost the opposite if the kid can register you as somebody who maybe has cared for them, or showed them kindness, or if you prove that to them through your interactions.

Similarly, Beth reported “we don't know when a kid is going to open up to us. We don't know who he's going to trust enough to tell them all these problems.” Similarly, Alex reported that these connections were “very case specific, client specific, resident specific.” Moreover, in Krystal's experience “if the boys didn't like the staff member, there was no way of deescalating the situation; which was the case a lot of the times.” Thus, the residents at Mountain View were not simply passive recipients of interventions provided by individuals with strong “people skills.” Instead, they would actively choose whom they liked and whom they trusted “enough” to interact with in a natural and meaningful way.<sup>39</sup> While these walls may often be insurmountable—as indicated by Krystal—in Tina's experience it was still possible that a direct-care worker could “prove” to the resident they were a kind and caring person through their “interactions.” For example, Luna reported “not every boy in that house liked me. That was

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<sup>39</sup> While Foucault's (1965) critique of the “science of mental disease” indicated that it was often limited to “observation and classification” and that it “would not be a dialogue” (p. 250), my colleagues suggested that not only was a dialogue needed to intervene with these kids, but also that these kids were actively engaged in deciding whom they would have a dialogue with. Further, although the monologue of psychology dictated that direct-care workers were to observe and classify the behaviors of youth according to preconceived diagnostics, my colleagues often listened to youth and questioned the veracity of psychological knowledge and its diagnostic understandings. That is, they resisted the imposition of psychological understandings.



alright with me. I wasn't there for a personality contest, but I'll guarantee that every boy in that house talked to me about one of their many issues at one given time or another.”

At Mountain View, Luna was commonly recognized as a natural who had a unique ability to connect with troubled youth. Nevertheless, even Luna experienced that her interactions with youth could not be forced. That is, even strong “people skills” had their limits. However, her acknowledgment that she wasn't there for a “personality contest” demonstrates that her efforts weren't invested in forcing the boys to like her or trying to win their approval. Although Luna was not liked by all of the residents, she was okay with that. Yet, all of the residents eventually talked to her about their issues. Indeed, according to my participants, a key to effective interactions was empowering the residents to be the ones who opened that door when it felt natural for them to do so, rather than forcing them to interact and share what they were going through. According to Jimmy, “we're there to . . . basically interact with them and help them to feel comfortable. When they feel comfortable with you, the more likely they are to bring things out and they're more likely to show how they really are.” Similarly, when Beth discussed the utility of psycho-educational groups, she reported that, in her experience, they were “one of the ways to get to know the kid. You give them time just to respond to you.” Ultimately, effective direct-care workers provided troubled youth with opportunities to open up on their terms and according to their level of comfort.

Although likeability and trust could not be guaranteed—even among those with strong “people skills”—it nevertheless became clear in my interviews that when practitioners demonstrated that they genuinely cared about the residents and that their caring was reliable, the kids would often open up when they needed someone to talk to. Thus, not only were effective interactions unforced, they were also guided by genuinely *reliable care*.

### *Reliable Care*

According to Mountain View's practitioners, troubled youth needed interactions with people who *cared* about them. Although this may seem obvious, the behavioral design of the program did not address caring as a necessary component of the intervention. Yet, my colleagues came to see caring as being absolutely indispensable. For example, when I asked David what he thought these kids needed, he responded "somebody to give a damn about them." In Charlie's experience, "they need to have it shown that people care about them and love them." Tina reflected, "what I think gets overlooked so much is that they're kids, they're children. So, let's take the behavioral health piece out of the way for a minute. What do they need? A warm place to stay, warm meals, love, somebody to care about them, to be encouraged and motivated, to be believed in, to be trusted, to be given responsibility . . . (pause) . . . those are all things . . . (pause) . . . those should happen first."

At Mountain View, it was common to hear practitioners say that troubled youth needed people to care about them. In fact, caring was repeatedly mentioned as a skill that was vital to work with these youth. In Alex's experience, "caring about the kids is important . . . (pause) . . . I don't know how you would provide therapy if you don't like somebody." To be effective, Luna believed "you have to give a damn about these kids." When I asked Gary about the skills that were needed, he told me "I think the more empathy and compassion that someone has for other people, the better their chances are."

As indicated by Gary, empathy and compassion can manifest in varying degrees. Further, run-of-the-mill empathy might not cut it. Indeed, "giving a damn" and "caring" tended to capture the depth of feeling most practitioners felt was necessary. While caring could be faked or conveyed in a half-hearted manner, it was also a common experience that the kids at Mountain

View could tell who cared about them and who didn't. According to Krystal, when direct-care workers "don't really care" about the kids and "just want to get [the] job done and leave at the end of the shift" that was problematic "because the boys need more than that" and "because the kids can tell: completely; absolutely. They will say to you like 'why do you even work this job, you know you can go work somewhere else and get paid.'" When I asked Dylan if the ability to care was required, he replied "I would say to do the program and to be effective, yeah. Because, I think the kids will know if you care about them or not and they will respond in kind." According to David, "these kids smell bullshit a mile off." When I asked him what he meant by that, he stated "if the kid thinks that you don't honestly give some sort of damn about him, he ain't gonna open up to ya. He ain't gonna function around you." Similarly, Gary reported "these kids have to know that you're going to be honest, genuine and sincere with your direct-care assistance, and if you do that and portray it, then they will listen to you, interact with you..." At Mountain View, it was commonly understood that caring had to be *genuine*.

Although Mountain View had plenty of direct-care workers that appeared to be there just for a "paycheck," it also had a collection of workers who seemed to genuinely care about the kids. In fact, some direct-care staff appeared to be primarily driven by care and empathy. For example, when I asked Beth what she liked about the job, she stated "I like just taking care of the kids. Being around the kids. Being able to teach them something if they don't know how to do it . . . I like to help them. I like to see them smile: being able to enjoy themselves." When I asked Luna why some direct-care workers stayed on the job despite the low pay, she replied "because they care and that's the catalyst between them leaving and [staying]." Similarly, Daisy reported "it's because you want to help these kids . . . because your heart is in it." In Tina's experience, "[h]aving people that truly care about the kid" was necessary. Unfortunately, she often

encountered direct-care workers who weren't adequate, and, in her experience, it was because "[t]heir heart isn't in it. The ones that stay are the ones that truly have a desire to help a child. The ones that come and go are just here for a paycheck and the kids will identify that and weed them out pretty quick (chuckling)."

Despite the fact that these kids often had histories of juvenile justice involvement and had a tendency to be aggressive and occasionally violent, Jimmy explained to me "they're still kids. They still deserve the help. They still deserve assistance, and they should get it." In fact, being able to "make a difference" was often cited as a motivation for doing this work. As Charlie put it, "I liked the kids. That was probably the best part: being able to make a difference on a daily basis." According to Lance, "it's kind of rewarding when you can show the kids that 'hey there are people out there that aren't jerks' and do care about [them] and giving them that part that is missing. So that is kinda rewarding about the job." Lance explained further that "[b]eing able to develop those healthy relationships with them is definitely the rewarding part of the job . . . and trying to make a difference in their lives. Because, that's the whole reason why I'm here anyways." In comparison to upper management, David believed "the grunts, . . . the ones that have one-on-one interactions with the kids, they're much more concerned about helping out the kid and bearing the cost."

In sum, caring was viewed as something the kids needed and as a skill effective direct-care workers had to have. Moreover, the kids would notice when practitioners didn't care and the absence of caring would motivate these kids to "weed" those practitioners out. However, it was also commonly understood that genuine care was not sufficient to help these kids. Caring interactions also had to be *reliable*.

In random, unspecified, and undetermined moments, effective direct-care workers understood they had to reliably “be there” for these adolescents when they were needed. According to Krystal, effective direct-care workers had a way of “letting the kids know that you’re there for them and that you’re not just working this job because you’re working to get paid.” In her experience, “letting the kids know that you’re there for them” was critical because “different boys . . . opened up at different times.” When I asked David about his duties on the job, he replied “um, basically make sure that the kid follows his own program, um be there for him.” As indicated by Krystal, being there for these youths meant being there when they decided to open up and providing them with the opportunity to talk when they needed it. Interestingly, David notes that while following the prescheduled program was important, so was being there for these youths. Although effective direct-care workers knew that following the program schedule was important, they also knew that the kids benefited from a degree of flexibility: that is, being there when they really needed someone was critical.

Often, the key to showing troubled youth that your direct-care interventions are reliable is to demonstrate that you’re capable of listening when they need it most. In Gary’s experience, “I think that active listening is the most important thing that they can do and one of the things you don’t want to do with an emotionally challenged young person is to cut them off or not listen to what their concerns are because most of the time that’s all they’re looking for. I have found that out.” In a reflective moment, Jimmy recalled when one of the residents opened up to him about his aggression: “I asked him about it and kinda just let him talk about it and whatever he felt comfortable sharing and that’s when he told me.” According to Beth, “[t]here will be times when a kid, if they get to trust you enough, they’ll tell you everything about their life.” In her experience, the key was to “just sit there and listen. Let them tell you everything.” Gary also

added that when direct-care workers can show they can actively listen then “eventually you’ll gain the amounts of trust and recognition that you need to actually be able to help them.”

While trust can develop by providing these kids with a reliable ear, it can also develop by showing them you are a reliable person. According to Lance, it became obvious that many of these kids were “not having healthy relationships like they should be and that’s probably the reason why they’re here to begin with too.” Further, because “they’re struggling with having healthy relationships,” Lance found the development of healthy relationships to be “stressful.” Nevertheless, he came to realize that “sticking with it and trying to develop a healthier relationship” with them was the key because “when they do get shown affection, you know, they do just open up to that.” In Tina’s experience, caring about the kids, encouraging them, and believing in them are things direct-care workers “have to work on so they may take a while.” However, “once you have some of those under your belt . . . it makes working on their challenges and strategies a lot different. The kid is going to be a lot more receptive to the treatment. They’re going to believe you. They’re going to want to do well for—really—for you: to have that praise and those feelings and then for themselves later.” On 9/11/08, I reflected on the level of trust that had developed between one of the “worst behaved” kids at Mountain View and myself:

This particular kid is known as the worst behaved in the house and with the most problem behaviors. Yet, he behaves around me. While he assaults other staff, generally disrespects them and often ignores them, he listens to me and follows my directions when I work with him. He’s told me that he doesn’t trust these other staff. He’s told me that he knows I care. In sum, he acts one way around me and another way around other staff (Journal Notes).

In Luna's experience, "trust . . . developed and formed and these boys probably never ever had that." In a reflective moment, she stated "I believe that they truly trusted me because I did keep my word to them and I think that it was . . . a new experience for them because most of their lives they just were shuffled around." In a heartfelt moment, Luna proclaimed "I always fought for those kids." Thus, being trustworthy was only half the battle. You also had to show that you were reliable.

Although "trust," "being there," "listening," providing "healthy relationships" and "fighting for" kids certainly mattered, it was the reliability of these actions that was crucial. As indicated by Gary, trust would "eventually" develop when the listening, genuineness, and sincerity proved to be reliable over time. In Luna's experience, trust was facilitated not by simply fighting for the kids, but by "always" fighting for them. In Krystal's, Jimmy's and Beth's experience, "being there" meant being available to listen when the kids needed it. As Lance put it, providing healthy relationships required "sticking with it" despite the difficulty. Similarly, while Tina revealed that caring interactions "should happen first," she also disclosed that the efficacy of those interactions requires "work" and they "may take a while." Ultimately, regardless of how genuine the empathy and caring might be, that empathy and caring had to be reliable: that is, effective direct-care workers had to reliably be there for these kids when they needed it.

#### *Natural Points of Connection*

As my colleagues revealed their experiences of what worked with troubled youth, it became clear that naturals were able to establish natural points of connection with these adolescents. In keeping with the unforced nature of their interactions, these connections tended to be meaningful precisely because they were grounded in the intersectional realities of their lives and the lives of the kids they worked with. Instead of approaching these youth from the

standpoint of their generic titles as *behavioral health technicians*, effective direct-care workers connected with youth from the unique standpoints of where their gender, age, culture and life experiences intersected (see Crenshaw, 1991; Potter, 2015).

For example, when I asked David to describe his primary responsibilities, he replied “as direct-care: (long pause) . . . role model, big brother, teacher and prison guard all mixed together.” While the roles of “prison guard” and “teacher” are indicative of institutional roles, the roles of “big brother” and “role model” are indicative of natural roles that corresponded with his position in society as a young adult male. Similarly, Lance reported “I’m like a mentor and security guard at the same time.”

By way of contrast, when Luna discussed her connection with the kids, she told me “I think that main bond was because they saw me as a mother and because most of these kids either had, or came from, dysfunctional families and/or had no mothers at all. I think that it was easier for me to have that connection with them.” Luna would add that she saw her role as “a friend also.” As with David and Lance, Luna’s roles represented the intersection of her gender, age, and life experience. Rather than describe her role in terms of a masculine enforcer, Luna described her role as a feminine nurturer: “as a mother.” In addition, she also described the merging of a familial role (mother) with a non-familial role (friend). As a mother/friend hybrid, Luna’s intersectional roles not only provided her with natural points of connection the kids could relate to, they were also seen as the source of meaningful connections the kids ultimately benefited from.

According to Krystal, the “majority of the time,” Luna functioned as the therapist even though she was “not trained” to be a therapist. In Beth’s experience, “I think [Luna] was mainly the person that the kids talked to about their problems . . . they’ll tell everything to [Luna].”



When Charlie told me that having people who care was a “big thing,” he made a point of stating “I think it was really strong when Luna was there, because she was the motherly figure.” Indeed, Luna’s connection with the kids was commonly experienced as being uniquely beneficial. In fact, her connection with the kids was meaningful not only because she connected with them as a mother/friend hybrid, but also because she was Native American.

During the time of this study, approximately fifty to seventy-five percent of the kids at Mountain View were Native American. As a colleague of Luna’s, I knew she identified as half Eagle Tribe<sup>40</sup> and half Latina. When I asked her if being Native helped her connect with the kids, she responded “*absolutely*, it was all about . . . identifying...(pause) . . . and to be culturally aware of what their differences were as opposed to...(pause) another Caucasian culture...” She added “if I did not share that culture exactly with them, I knew of the culture, and that validating their culture was one of the big things for them to be able to get by. So, yes.”

When I asked Luna if being female helped her connect with the kids, she responded “yes, absolutely. Everybody always wants a mom. Moms are the ones that are supposed to make everything feel better. Moms are the ones that will allow you to cry and will cry with you and I think that me being a female... (pause) a Native female has helped because I understand where they’re coming from and I was able to connect in different ways other than let’s say, maybe, a male.” Thus, when Luna connected with the Native American youth at Mountain View, she provided them with natural points of connection that corresponded with the intersection of her gender, age, and culture. These natural points of connection were meaningful because of the importance of “identity,” the importance of “validating their culture,” and because of the importance of the motherly role among Native Americans.

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<sup>40</sup> To protect the anonymity of my participants, I have used fictitious names for the Tribes my friends and colleagues identified with.

When I talked to Beth—who identified as a member of the Bear Tribe—she told me “the way my parents taught me is that any kids that you come across, you think of them as your own kids. Once you start thinking of them as your own kids, you can relate to the family and that’s what I did . . . that’s how I related to this kid and then to the mother.” To explain further, she told me that “the kid understood that I talked to the parent about his behavior, and the things that are going on, and he got to know me better, and through that I got to know the parent, and the parent told me what to say to this kid, and how to work with this kid, and some things that I didn’t know about this kid . . . and then I would tell the parent . . . what works for him at Mountain View.” When I asked Beth if taking on that motherly role was part of her culture, she replied “it depends. Some people are taught that. Some [members of the Bear Tribe] are taught that, but not all of them. But, I’ve worked with so many kids . . . they’ve brought them and it’s just like handing over their kids and ‘here, here’s your son.’ In [Bear] they say . . . ‘here’s your son, take good care of him. I’ll be back on Friday’ or whenever they’re going to pick them up, ‘until then, you take good care of him.’ And then from then on, you take them in and then you start treating them as though they’re your own kids...”

Although the motherly roles that Luna and Beth took on may have a specific cultural resonance, it was also common to hear non-Native direct-care workers describe their intersectional roles as family-like. When I asked Charlie to describe his responsibilities, he responded “well . . . [when] they come home from school, we shuffle them in their rooms, we prepare dinner, we prepare activities, prepare itinerary . . . just like a parent would do for their kid.” Later in the interview, Charlie stated “I think a lot of their dads maybe abused them, so we’re kind of replacements, a little bit.” According to Dylan, “we are someone there to love and treat these kids like family: like they have somebody.”

Despite similarities, the natural points of connection that effective direct-care workers established with these kids were unique and represented the intersection of culture in addition to gender and age. For Luna and Beth, taking on a motherly role resonated with their experiences of their Native cultures. For Charlie and Dylan, taking on a family-like role resonated with their non-Native backgrounds.

At Mountain View, the life experiences of direct-care workers also intersected with their gender, age, and culture in the development of natural points of connection. For example, Don—who was a member of the Badger Tribe and who was familiar with the Bear Tribe—told me “I can relate . . . I can relate . . . because they’re [Bear], I would say a word and they would understand it...(pause) in their language.” Further, when Don described his role, he described it as “being able to be . . . a father figure. Because, you have to remember that most of these kids don’t trust males.” Moreover, Don explained that he was also able to connect with the youth because “I have experienced what they’re going through. If you’ve done it and been there, it seems like you are better able to connect with them.” Along similar lines, Tina reported “[i]n my personal and professional opinion, in what I’ve seen, people that have a life experience in the gutter—drug history themselves, come from a broken family themselves, had some bumps along the way—tend to interact and build those relationships better than some people I’ve seen come through [at a] Master’s level, which baffles me.”

As revealed by my colleagues, it was common for them to describe their roles as mergers of the familial with the non-familial: “big brother”/“prison guard;” mother/friend; “like a parent”; “like family;” a “father figure.” Ultimately, these intersectional roles provided direct-care workers with unique points of connection that appeared to be meaningful because they were natural and grounded in the lived realities of the youths they worked with. Because some of their

dads may have abused them, because some of them may have had no mothers in their lives, and because all of them had been left behind at Mountain View, it was common for direct-care workers to experience their family-like roles as being meaningful to these kids because they functioned as caring surrogates. Ultimately, when these kids urgently needed a caring adult in their lives, these practitioners functioned as unique “replacements.”

### Emotional Grit

The more direct-workers told me about what they saw as the attributes and skills needed to work with troubled youth, the more it became apparent that naturals were extremely resilient individuals. Over and over again, my participants revealed that the job was emotionally taxing and only a few had the resources to endure it. In fact, it was common to see direct-care workers become uncaring as the job drained them of their empathy. As reported by David:

I think some staff have come in caring and sympathetic and then as the job progressed that skill starts getting sucked out of them. They begin very sympathetic and then at some point they're like 'God, I don't care what happened to this kid, I'm going to murder the little bastard' (chuckling) . . . It's a very draining job and if you keep on dealing with the same crap from the kid day-in and day-out it gets rather old and you begin to forget that this is the only way the kid knows how to act.

When I asked Dylan if he encountered staff who don't care about the kids, he replied “it seems few and far between, because everybody wants to care. They're kids, you know. They've been through some pretty poor situations, but it seems like it's just too much work for some staff, where it overwhelms their sense of care or their sense of empathy. So, they become uncaring.” Similarly, Lance told me “sometimes the stress level with the kids can get to you at the end of

the day: if you let it. Especially when you first start, I think it does get to you.” He would add “dealing with behavioral problems . . . do[es] wear down on you, if you do eight, nine, ten hours of that everyday.”

At Mountain View, the “defiance,” the “attitudes,” and the “aggression,” were frequently mentioned as major sources of stress that could drain direct-care workers of their empathic resources. In fact, the emotionally demanding nature of the job was recognized as a key contributor to the high-turnover rate. For example, Alex reported “a lot of times . . . people leave us because they say ‘it’s not what I expected.’ I think you can sit in a classroom, talk about diagnoses, talk about behaviors; you know, this kid is going to curse at you, spit on you, but until they actually do it, you don’t know how you’re going to respond, and I think that’s the big issue.” When I asked David what he thought explained the high turnover, he stated that although many direct-care workers start out with good intentions of wanting to help kids, “they don’t want to be spat upon, called everything under the sun, um punched occasionally; just deal with all the crap that these kids can dish out on you.” In fact, David revealed how his own limits were tested two weeks into the job. As he recalled:

[O]ne of the Asperger/autistic kids . . . was trying to AWOL and I had to run after him and put him into a full-nelson. He got angry and when I tried to put him into a prone hold, he wasn’t having any of that. I ended up getting punched three times in the head, spat upon and I was debating how much I really wanted this job and if anyone was really going to fault me for dropping an elbow on this kid’s head [sarcastic tone]; but about five hours afterwards, I was laughing about the whole situation. Granted, I’m a glutton for punishment. I don’t know how many other people really want to deal with that crap.

Despite having been to the brink of his capacity for caring, David was able to rein in his thoughts of meeting aggression with aggression, pull from his emotional resources and laugh about the ordeal later in the day. Instead of quitting after just two weeks, David stayed on the job and would become the most tenured direct-care worker at Mountain View. Although he referred to his resilience in a self-deprecating manner—“glutton for punishment”—his ability to take what the kids could “dish out” was commonly recognized as a necessary skill and one that the kids would routinely “test.”

For instance, when I asked Daisy what she thought were the strengths of the program, she replied, “the resiliency of the staff. I mean there are few of you that have stayed around for a very long time and that’s a huge one because kids will try to run staff off.” In her experience, the “kids” are “going to test you. They’re going to poke at you.” Echoing Daisy’s sentiment, Charlie revealed that when new direct-care workers came to Mountain View “the kids would test them.” Similarly, Dylan told me, “generally, you could say our kids . . . immediately push anybody away. They immediately test you; so they do not listen to demands.” Likewise, Beth reported, “I think more of the kids are trying to see what they can get away with because we’re always watching them . . . I think they’re just trying to find different ways of seeing if they can get away with something” (see Foucault, 1977; Rhodes, 2004). When I asked Lance what made the job stressful, he replied “repeatedly having to deal with certain residents over and over and over: repetitive things that they keep testing you or pushing you on or aren’t following in compliance with.”

At Mountain View, new direct-care workers would find themselves being tested by the kids they worked with. In this context, they would discover the depths of their empathic resources and would come to recognize the attributes and skills that enabled them to work

effectively with troubled youth. As my participants discussed what it took to work in this type of environment, they revealed that it required *emotional grit*: a combination of *extreme patience*, an *extremely thick skin*, and *extreme resilience* in the face of routine trauma, crisis, and chaos.

### *Extreme Patience*

To get through the day at Mountain View, run-of-the-mill patience would not do. According to Jimmy, “you got to be able to have a lot of patience in dealing with kids who might actually threaten you, scream at you, yell at you.” Succinctly, Lance stated “it takes a very patient person” to do direct-care work. Dylan went so far as to say “I think the most important part is patience.” For example, Dylan revealed that “the typical day would see ‘Johnny’ not listening to you and then, after multiple interventions, an hour later maybe he is talking to you about a lot of stuff.” In his experience, direct-care workers could reach troubled youth as long as they were willing to try “multiple interventions” and be patient with them. In practice, however, this was not easy. As revealed by Lance, “that’s tough to do—every day: it’s a tough thing to do. Tough to keep your patience and not just want to strangle the kids because they definitely get on your nerves; but to work through it and to talk with them and process with them.” When I asked Don if there was anything he wished he had received training on, he replied “I’d say patience. Patience in a crisis.” While it’s possible that patience can be trained, it was clear that *extreme patience* was needed to work effectively with youth who frequently do not listen and who frequently go into crisis.

### *Extremely Thick Skin*

In Jimmy’s experience, being patient with kids who “threaten,” “scream,” and “yell” was only part of what it took to be effective in practice. In addition, direct-care workers had to be “able to deal with that in a positive manner.” That is, an effective direct-care worker would not

let threats, screaming, and yelling get to them. According to Lance, “[y]ou have to have thick skin—very thick skin—and, you know, the first couple days, you know—me getting thrown into [restraints] and being thrown into the full swing of things—a lot of the times that’s going to scare the average person off... It definitely takes a different person.” In this poignant statement, Lance not only indicated that a “very thick skin” was needed, but also that, in his experience, the “average person” didn’t have what it took to do direct-care work. When Dylan was describing to me how the youth at Mountain View showed their anger, he stated “[a]s a whole, their anger problems are there, but it’s generally under control. You could have a kid yell at you...(long pause). I guess my idea of ‘under control’ is different from most peoples’ because I’ve had kids cuss, yell, you know, push me, throw things at me, cuss at me, bite me, spit on me and I would say that’s not as bad: that’s not the worst anger problems. You know, I’d say hitting holes in the wall and breaking down doors would be serious anger issues.” In this statement, Dylan not only reveals that he is able to handle the cussing, yelling, pushing, biting and spitting that comes with the job, but also that he recognizes his level of tolerance as being “different” from what “most” people have. Similarly, when I asked David to discuss the types of behaviors he encountered on the job, he replied “um, well, I’ve been called everything under the sun. I’ve had some pretty imaginative names thrown my way... I’ve [been] spat on twice. Some of the staff have been spat on much more than me.”<sup>41</sup>

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<sup>41</sup> As “contained secondary adjustments” (see Goffman, 1961, pp. 199-200), the development of extreme patience and an extremely thick skin demonstrate the degree to which practitioners felt that strict adherence to disciplinary techniques was excessive as opposed to an efficient exercise of power (see Foucault, 1977). Instead of exercising a relentless ‘micro-physics’ of disciplinary power (see Foucault, 1977, p. 139), practitioners often believed that disciplinary responses weren’t always necessary. As revealed by Dylan, disciplinary techniques were occasionally reserved for more serious behaviors.



Echoing these sentiments, Alex recalled that when he was a direct-care worker, the youth he worked with “could swear at me and, you know, call me all kinds of names. It was fine.” In his experience, “you become somewhat conditioned: where these things just don’t bother you anymore and so you kind of, subconsciously, just assume that your staff are dealing with it in the same way.” However, Alex acknowledged that “one of the major issues [is] that staff tend to take things personally . . . and . . . [it’s] easier said than done: ‘don’t take it personally.’” Indeed, Daisy believed “it takes a special kind of person to work in a place like this where you know you’re going to be, you know, assaulted somehow each day; either physically or emotionally or verbally.” Thus, regardless of whether a “thick skin” was a natural attribute or a skill “conditioned” through experience, it was commonly understood as necessary to work with troubled youth. Yet, it was a qualification many did not have.

#### *Extreme Resilience*

In addition to having extreme patience and an extremely thick skin, direct-care workers also had to have *extreme resilience* as the day-to-day nature of the job required staff to repeatedly confront trauma, crisis and chaos. When Jimmy told me that the job was “more than what I expected,” he explained “the more part was the aggression, like coming from certain group-home members. . . . I mean that type of aggression, I was like ‘wow’ it kinda freaked me out. I think it was the second day when I showed up for observation and one of the kids got put in a hold and he was screaming for like close to thirty-forty minutes and you heard kind of like these primal screams and it’s not that the kid is getting hurt, they just put him in a hold and he’s really pissed off because he wants to go home and that kind of struck me like wow, whoa [laughing]” (see Bath, 1994; Rhodes, 2004).

Similarly, when Gary was a direct-care worker, he recalled “I wasn’t ready for the amount of emotional residue that the kids had. It was a little bit overwhelming at first.” When I asked him how that emotionality manifested, he replied “just the intensity of it—you know—it was like way beyond anything that I would call . . . normal . . . . Because, when it happened it was usually somewhat on a grand scale, you know. Not that it was a life and death situation, but they were treating it like a life and death situation.” Further, he would add “I think that that’s one of the reasons that direct-care suffers those huge amounts of burnout too because they don’t even know what it is that they’re up against.”

When Dylan explained how a prototypical “Johnny” might begin talking “about a lot of stuff” after an hour of “multiple interventions,” he went on to state “two hours later he’ll have an issue he doesn’t share with anybody else and he builds it up inside of him and starts cutting his wrists. So, I’d say maybe an incident like that—a serious hurting yourself or trying to run away—would generally happen about once every week.”

At Mountain View, it was common for new direct-care workers to be shocked and overwhelmed when they encountered trauma and crisis for the first time. Although these encounters did not happen every day, direct-care workers had to be resilient because—as revealed by Dylan—they did occur with regular frequency. When I asked Dylan if the job was what he expected, he told me “um, not at all.” He explained:

I think when you think of these group-homes you think of this structured, like crystallized, like everything is set-in-stone environment when in reality it’s more of an organized chaos. It’s a volcano that’s going to erupt at any moment type deal, versus this pristine, hospital-like environment I pictured.

Similarly, Jimmy told me “there is a certain amount of disorder, you know, so you gotta be able to kind of adjust to it.” He would explain “you got to be able to deal with the environment where you got eight kids running in different directions and you got to be able to go with the flow, adjust to the program.” In this type of environment, Jimmy stated “you never know what to expect . . . Because, one day they’re really nice and the next day you could have a crisis or something; someone could end up being put in a hold and the typical day is you just got to be ready for whatever type of situation comes up.” According to Krystal “[w]e had a set schedule of what we were meant to do, but a lot of time it would get kind of intervened because of a boy’s outburst and then the whole domino effect of one boy being upset and all the boys being upset.” When Lance was explaining to me what was “stressful” about the job, he stated “I mean, one minute I can be putting a kid in an ESR [emergency safety response]—you know—putting him in a hold, the next minute I’m reading him bedtime stories. So, it’s that kind of relationship where it’s a rollercoaster.” Using the same analogy, Charlie informed me “well, overall it was kind of a rollercoaster ride on a daily basis.” He would explain “a lot of time [sic] they did obey the rules, but then certain behaviors or thoughts would come up, and just throw them out the window.” Further, Charlie told me that when the kids tested new direct-care workers, they would “get away with things and then we’d have to try and make up for that and it gets all chaotic.” When Charlie eventually resigned, he said it was “just because it was too stressful. It was really getting to me and just getting tired of it: a daily basis of problems kind of builds up.”

At Mountain View, where trauma, crisis, and chaos were frequently encountered, David believed direct-care workers needed “bravery in some aspects (chuckling)” to be qualified for the job. As Krystal explained “Um, I’d seen fists go into the wall, I’d seen heads go into the wall, I

experienced injury, um, personally, from it, during a restraint.” Yet, Krystal kept coming back to work until a serious injury made it impossible for her to return. Although Dylan recognized that the job was incredibly difficult, he believed “you can do it, it’s just gonna be hard.” According to Daisy, “[y]ou’re going to encounter all kinds of abuse while you’re here..” In her experience, “these kids are tough. They’ve had little in their life that’s given them hope or they wouldn’t be here and the staff that have stayed here, I think, are amazing people. I mean, there’s a huge degree of burnout. I recognize it. I can see it. It’s obvious. And the fact that you guys keep on staying is tremendous and it’s amazing and my hat’s off to you.”

When I asked Gary what he looks for when recruiting new direct-care workers, he replied “it’s very difficult to tell, because I . . . found you do not read the book by its cover. Because, I have met remarkably strong—resilient people—who, if you would look at them, you would go ‘I’m not even sure they can do this’, but again . . . I’ve met very established, very intelligent people who will take one look . . . and literally run.” When I asked him what areas of training could be improved, he replied “resilience and confidence. Those are the two areas and I don’t know how to train that; I’ll be honest with you . . . I have found that I cannot teach that very well. Somebody has to actually already understand, at least to some degree, that they have those elements.” Although *extreme resilience* was needed to endure routine trauma, crisis and chaos, Gary was at a loss of how to recruit people who had it and he was even more perplexed about how to develop it in those who didn’t.

### Consistent Care

My colleagues at Mountain View repeatedly indicated that care had to be consistent. However, in order for care to be consistent, practitioners had to be aware of their own personal limits, they had to be able to maintain strong boundaries, and their efforts had to be united with a

caring collective. Although some direct-care workers had the awareness that was needed and some worked hard at maintaining appropriate boundaries, a caring collective was never fully realized because of the larger structures that made the retention of naturals nearly impossible and the recruitment of weak staff inevitable.

### *Knowing Your Limits*

When Jimmy told me about the skills needed for direct-care work, he stated “I think [the job] does require at least some self-understanding about yourself, because if you don’t understand your own emotions, your own problems, or you haven’t confronted your own issues and these kids come up to you and ask you about something, it’s really difficult to put their problems into perspective if you can’t put your own into perspective.” According to Daisy, “you really have to have an idea of who you are, what you’re willing to put up with and what is your motivation for being here. You have to know yourself or you’re never going to succeed.”

During the hiring process, Daisy believed the company should have recruits “take an inventory: what are your limits, what are your triggers? Think very carefully about why you’re here.” When Alex explained to me how he tries to educate staff about the residents’ behaviors, he stated “the way I always explain it to staff is that we all have our limits. I mean, I don’t know about you, but, you know, I’ve thrown my pager before over the years, my phone, put a hole in the wall because I was just so upset and really, I think everybody has their limits.” He would add “I mean, how many times have staff said that, you know, ‘I can’t take one more thing.’” Indeed, when practitioners weren’t aware of their own issues, triggers, and limitations, boundaries that should be maintained were crossed.

### *Maintaining Strong Boundaries*

Although Jimmy and Daisy believed it was important for practitioners to understand their “own issues,” “triggers,” and “limits,” Alex believed that “[m]ost people bring—kind of—their own parenting baggage to this position.” He added, “I think that the therapeutic response is a lot different than how we were raised or how we might raise our own children. I mean, I’ve got a child...(pause). I don’t have him on a point system. But, I think that the consistency is really lacking in the group home because of that. I would say that’s the biggest issue.” In his experience:

I think there’s a misconception that all these kids need is, you know, a little love and some direction and they’re going to be fine . . . I think there’s all kinds of boundary issues. I think staff tend to divulge too much information about themselves. They relate to the kids. Maybe they’ve experienced similar situations from their past, whether it be drug addiction or they were abused as a child. I think a lot of times staff have a real problem having strong boundaries with the kids.

Ironically, it would appear that the meaningful connections that enable practitioners to work effectively with troubled youth can also present the risk of crossing boundaries. On the one hand, the intersectional realities of practitioners’ lives can provide the residents with meaningful points of connection that are beneficial. On the other hand, they can also open the door to boundary-crossing, such as when practitioners divulge “too much,” relate too closely or have their own issues “brought to the forefront.” In other words, the intersectional realities of gender, age, culture and life experience can be a double-edged sword.

When I asked Luna if she ever felt like she was “too close to the guys,” she replied, “I think so. I think that there were some days that I would come home and, because they required so

much of me, not just because of my position, but because of that mother figure stigma that I might have had . . . that sometimes it was just so draining that sometimes I'd just go home and I'd just cry rivers because there were just some things I just wasn't able to help them with. So, yeah, I think that my emotional stance with them definitely played a huge part in some things that I could have done differently.”

Ken: Like what could you have done differently?

Luna: I think that I would have probably put a boundary that was more geared to them having a rapport with their own people. I would have pushed it more on that end instead of thinking that I could hold all their problems, as well as mine, as well as the company on my shoulders. So, I think that drained me and there were times where I just could not function to the capacity that I feel that I am able to function.

Ken: Because, maybe, you just took on too much?

Luna: Way too much . . . way too much.

Although Luna's "mother figure" role may have been culturally appropriate, it nevertheless pushed the limits of what she could handle. Emotionally, she let herself get too close and she took on too much. When she couldn't help them with particular aspects of their lives, she found herself crying "rivers" when she went home. In retrospect, she would have worked at maintaining a stronger boundary and would have emphasized the need for the kids to have "a rapport with their own people."

When Charlie told me that Luna's "motherly" role was beneficial for the kids at Mountain View, I asked him if he ever experienced staff being "too emotionally involved?" He replied that Luna was and explained that "sometimes she got to the point of crying along with

them, because she kind of felt how they were feeling and it was as if she was actually a mother to them and uh, yeah...(pause) really putting herself out there.”

Ken: Did you ever feel that it was inappropriate?

Charlie: I don't think it was ever inappropriate, because they really needed that at the time, but it did kind of push the boundaries.

Ken: Like in what way?

Charlie: Well, I mean, she'd hug them and everything and then get pretty close to them, so...(pause) it kind of invaded their space, but, at the same time they did need it so I think it was acceptable.

Ken: Did you ever think that those kids felt like their space was violated or invaded?

Charlie: Not by her, but maybe by the other staff.

Interestingly, Charlie simultaneously believed that Luna's interactions were “needed,” but also pushed the boundaries. While he didn't believe her interactions ever crossed those boundaries, he did believe that other staff would have if they had engaged in similar behavior. Indeed, Krystal revealed that she actively avoided giving similar types of hugs because of her intersectional position. According to Krystal, “I think that there's boundaries that you need to maintain; especially being a female on staff. When a boy wanted to give me a hug, I kind of turned my body for more of a friendly hug than it was anything else. Same with other female staff; we did that. Definitely, you can't get too emotionally caught up with them.”

Given Krystal's age—nineteen—it's very likely that when she gave these adolescents a “hug,” it could be experienced and interpreted quite differently compared to when Luna—as a mother figure—would hug the kids. Thus, Krystal worked at maintaining appropriate intersectional boundaries—that is, boundaries that were both age and gender appropriate—by



giving these adolescents “friendly” side-hugs. Nevertheless, Krystal also revealed that the connection she was able to establish with them—as evidenced by the kids wanting a hug from her—presented her with the dilemma of getting emotionally “caught up with them.” In fact, the qualifier “too” suggests that her connection to the kids was an emotional one, albeit one that she kept in check. That is, she worked at preventing her emotional connection from becoming “too . . . caught up.”

### *A Caring Collective*

At Mountain View, it was commonly understood that a collection of caring practitioners was the catalyst for what works *in practice*. That is, the network of relationships youth are exposed to should be made up of a caring collective. For example, when I asked Dylan how he would describe the job to a friend, he stated “the best part is you’re gonna come work with your friends, like people that actually care, that will really make it happen.” When I asked Charlie about the strengths of the company, he stated “[w]ell, I think we do get people in there that care about the kids and that’s a big thing.” While Charlie also acknowledged the “structure” of the program as a strength, he clarified “I think it’s mainly the people, really. If you don’t have the people, it’s not going to work.” When I asked Tina about the behavioral program she told me “I think they’ve gotten way off in right field trying to make it way too complicated . . . To me, honestly, it’s horseshit. It’s horseshit because what is changing these children’s behaviors is the relationship between the staff and the compassion and the nurturing and those kind of type things . . . I don’t believe that it’s okay, necessarily, we taught you how to do this and now you’re all better. I don’t think that works like that.” According to Luna, “I think that a lot of the therapeutic value came from within the house. It came from within the house where people

actually cared about them.” Thus, within the behavioral structure of the program at Mountain View, it was understood that it was a caring collective that makes it happen.<sup>42</sup>

However, that caring had to be consistent among its practitioners. According to Don, “that care has to be consistent. Everybody has to be on the same page it seems like.” In Luna’s experience, “[y]ou have to truly care about them and not just have a façade of ‘oh yeah, I care about you this day, but, you know what, I feel really crummy this day, so I don’t care;’ it’s gotta be consistent care.” She added: “when you’re dealing with people’s lives, it should always be a hundred and fifty percent.” However, in her experience “when you hire people out of desperateness” and don’t pay them sufficiently, “when you have kids that really need you, whose gonna be teaching you? A bunch of dumb asses that don’t even know and care about what they’re doing.” When Charlie told me about the negative aspects of the job, he indicated that Mountain View had “a whole bunch of new staff, so the consistency went down a lot and it was getting kind of chaotic.” Moreover, in his experience “I think all staff put on the appearance that they cared about [the kids], but some generally didn’t.” According to Dylan, “[w]e’ve had staff before that were on prescription medicines that visibly affected their job performance and I didn’t understand why they would be employed with us in the first place to begin with. Um, I’ve had staff that obviously had their own emotional disabilities which vastly affected their job performance.” When I asked Alex about the ratio of staff who did what they were supposed to versus those who didn’t, he replied: “if we base it on the ideal, I would say we’re probably at

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<sup>42</sup> Although Mountain View can be seen as an extension of the “carceral continuum . . . over the . . . threat of delinquency” (Foucault, 1977, p. 297), its practitioners came to realize that a caring collective was needed to transform these kids as opposed to a collection of social worker-judges who exercised disciplinary power (see Foucault, 1977, pp. 304-305). Indeed, to the extent that interpersonal skills—such as caring—were seen as necessary, they suggest that empowering techniques—which nurture and support the ‘soul’ of the child—were needed, as opposed to using disciplinary techniques to produce a ‘soul’ (see Foucault, 1977, pp. 28-30).

about forty percent” who actually “do what is expected.” When Krystal lamented about direct-care workers who were there just for a paycheck, she stated: “they’re there and that’s it . . . that’s not going to help the kids at all.” When I asked her how many of her colleagues cared, she told me “off of my head, I would say that, including myself, like five staff members out of maybe . . . like fifteen.” I asked if that was about a “third” of the staff, she reiterated “yeah, a third probably.” She then added: “the people that cared about the kids are still there to this day, as opposed to everybody else who just left and new staff coming in.” Whether the percentage of competent direct-care workers was thirty percent as suggested by Krystal or forty percent as reported by Alex, it was clear that in their experience the majority of direct-care workers were *weak staff*. Thus, the provision of consistent care was not only a challenge, it was nearly impossible. To say the least, the kids at Mountain View were exposed to a disarray of therapeutic relationships.

#### Weak Links

At ABC, a high-school diploma was all that was needed to be a direct-care worker. Although some of these workers were recognized as being “amazing,” Tina—the regional manager—reported “a lot of times we get the caliber of people that should be flipping a hamburger.” In David’s experience as a direct-care worker, “they’ll hire a bum at the bus stop just to fill up holes in the company.” Similarly, Dylan told me “a lot of times . . . the staff that we had weren’t adequate.” In his experience, “we’d need—in the first case—qualified staff” to be able to achieve ABC’s mission. According to Krystal, “I think one of the weaknesses would be the staff members.” That is, “hiring staff members that have no intentions of really helping.” When I asked David if Mountain View’s program had any weaknesses, he answered: “Um, weak staff.” At Mountain View—the very first group-home ABC opened—it was common for its staff

to indicate that quality workers were hard to come by and that kids were often exposed to poor quality practitioners.

Although complaints about weak staff were frequently brought up in the interviews, I noted in my research journal how Mountain View was becoming overrun by weak staff after Luna was fired and the core of Mountain View's naturals began to leave. On 10/9/08, I wrote about a shift that I had worked with the new house manager, who I considered to be weak:

Throughout the shift I noticed how much the behavior of the boys had changed. I had become very accustomed to the boys following my directions and generally complying with the rules or at least understanding and being apologetic when they broke them.

While the boys were relatively behaved—meaning no crisis occurred—they would roam around the house, leave my supervision and go where they are not supposed to without asking first. When I called them on this behavior they acknowledged that they should, but it was with a reluctance that indicated to me that other staff were not holding the kids as accountable. During a “wrap-up” meeting, a new resident, who I had just met briefly the week before, was rolling around on the ground and doing hand and head stands on the floor as the house manager conducted the meeting. I waited as patiently as I could for her to say something to the boy but she just ignored him. Another resident, with whom I have a good rapport, started to act up as well: making funny noises. I then interjected and talked to the boys about proper behavior during a meeting and the new house manager just listened to what I had to say without contributing or even supporting what I said.

When they both started to act up again, she again just completely ignored them. I was so distraught by this scene that I initially felt like I wanted to leave and quit. The work that I had put into the house over the last year had seemed to go down the drain because there

was no one left to follow through with how we had run the program. The boys were allowed to do whatever they want much more frequently than had been the case when I was working full time and when the other strong staff had been still working at the house. I was the last one left and it was a losing battle; especially working only once a week now (Journal Notes).

On 10/12/08, I again lamented about weak staff in my research journal and how they facilitated chaos. In particular, I wrote:

Throughout the shift, kids wandered away from both staff and walked right into the kitchen to help themselves to whatever they wanted. I interrupted this and reminded both the kids and staff that the kitchen is off limits without permission and that kids are never to wander away from staff without having received permission. Whenever I saw a kid where I suspected he wasn't supposed to be I would politely ask them 'did you get permission' and then would immediately follow up by asking their assigned staff. The kids who knew me from my fulltime days, fell back into the routines I had helped establish this past summer. The new kids had a harder time with it, since I suspect this is the first time they've been held accountable for non-crisis behavior. Eventually, they followed the lead of the other residents who respected my wishes and complied with the former house rules . . . [W]hen I took two residents on an off-site outing and left . . . two staff to manage four kids, a crisis occurred. When I got back to the house, the house alarms were going off and couldn't be shut down. More importantly, two residents had gone AWOL. On the one hand, I wasn't surprised that a crisis broke out while I was gone. My first thought was to question whether I should have stayed and had one of the other staff do the outing. Yet, it was quite possible that a crisis might have occurred on the

outing while things remained calm at the house. Plus, it was reasonable to expect that two staff could manage four kids (Journal Notes).

As I reflected on this double-bind, it became clear that crises are not only facilitated by weak staff but also inevitable when there isn't someone there to hold them accountable. During that same shift, I noted how a direct-care worker who I considered to be "seasoned" yet "very weak" facilitated chaos:

[W]hile we were having dinner (with the two residents who eventually wandered back to the house after about thirty minutes) one of the residents who had taken off earlier, got up from the dining room table, right across from her, and walked away going right out of eyesight. He was calm and most likely not an AWOL risk, but he was leaving our supervision. I politely asked her where the resident went, and she exclaimed 'I have no idea.' Her reaction was one of exasperation and one of powerlessness: as if she could not have prevented it. I reminded her that residents needed to ask permission to leave the table, and her interpretation was that this child violated house rules (as opposed to her lack of holding the child accountable in the first place). What would happen if I wasn't there?" (Journal Notes).

In my experience, I noted that "[o]ver the two years I've worked with this company, this basic routine of holding kids accountable for attempts to leave supervision keeps crises to a minimum. Granted, it is constant work to maintain this routine, but when it is established as routine, the program runs much smoother and everyone is safer" (Journal Notes). However, while "[s]ome staff . . . realize the logic of managing the little things to prevent the big ones . . . other staff only do this when told to while others never do it" (Journal Notes).

By way of contrast, the very next day I wrote in my journal:

I was working with a new staff who I would consider [to be] the one strong staff of the new bunch. She was thankful for working with me. She referred to me as a strong staff who had a calming effect. Several weeks back, when she had just finished her observation shifts she requested to shadow me on my shift because she felt that she learned nothing from the seasoned staff she had observed (one that I would call seasoned but weak). I remember that shift as being a busy one and feeling disappointed that I couldn't coach her more. She said that she learned a lot just by watching me and I remember her commenting that night that I had 'actually interacted with the kids.' Between the two of us, we had an excellent shift. The four kids followed our directions and began to ask permission for the little things (Journal Notes).

Although Mountain View was based on a behavioral design that is backed by science, it regularly failed to ensure that all of its workers were capable of establishing the therapeutic relationships that are necessary to implement that design. According to my colleagues, the kids at Mountain View were routinely exposed to a network of dysfunctional relationships: one that was riddled with weak links. While naturals attempted to coach new staff and guide them, weak staff—both seasoned and new—facilitated chaos.

“some people never show up after the training”

Instead of providing kids with consistent care, ABC constantly exposed its clients to an endless cycle of new staff. According to Alex, the turnover rate at ABC “within a year [is] close to one hundred percent.” In Daisy's experience “we have a huge attrition rate, which is unrealistic. It's just unreasonable to have that big of an attrition rate. It's ridiculous.” When I asked her about the turnover rate at Mountain View, she stated, “I would say its at least eighty

percent and sometimes it's a hundred percent within six months." Because turnover was a constant, consistent care was impossible to maintain.

When I asked Don if there was anything that could be improved in the program, he replied "to retain staff. It's been a persistent problem actually. The important thing is that there has to be some sort of consistency for the treatment of the kids and if you don't have that... (pause); people coming and going: it's a musical chair, you know..." He added "[t]here's turnovers all the time. I see that all the time. We need somebody that can stay a while." When I asked Charlie if the company had any weaknesses, he responded: "I think the biggest one is the high turnover rate. The consistency goes down and then too many variables get involved." When Krystal told me about what made work "hectic," she pointed out that "there was new staff members always...(pause); like a big staff turnover." In her experience, "since there was a changeover in staff a lot of times and a change over in boys, it was hard to get some kind of set base on them...(pause); of like 'this is what you do when this boy does that,' especially when they change. They change because staff changes or they change because other boys come in and go." According to David, "staff turnover" was one of the major weaknesses of the program. After a little over a year on the job, David told me he was "the longest working person in the house." Everyone else had "come and gone." In his experience, after "three months, you're an old man. Um, some people never show up after the training. There was one guy who told me he just needed to move his car. *I never saw him again* (chuckling) . . . and that's only after him being there for maybe thirty-five minutes in the house." David explained that this person "was observing for that shift and he met only one of the kids and that was *one of the good kids*."

Although a caring collective was needed to provide consistent care for troubled youth, the care the kids received at Mountain View was generally inconsistent. While the group-home did



have a collection of caring practitioners who tended to stick around longer than most, it also had a collection of weak staff who continuously cycled in and out of the program, creating an atmosphere of chaos rather than one of consistent care. While it would be easy to demonize ABC's profit-motive, the findings from this study indicate that the dysfunctional network of relationships the kids were exposed to ultimately emanated from the cost-control mandates of the state and the precarious balancing act it expected of its providers.

### The Managed-Care Tightrope

As a state contractor, ABC bid to provide Medicaid managed-care services at a low cost (see Freeman & Kirkman-Liff, 1985; Kirkman-Liff, et al., 1987; McCall, 1997; Rosenblatt, 1985). In theory, the competitive nature of the managed-care market motivates its for-profit players to pursue ever-efficient services as they balance the delivery of care with the pursuit of profit under the cost-control mandates of the state. In theory, these potentially conflicting priorities can be balanced. In practice, however, Alex described it as the "toughest" part of his job. Although Alex insisted that the profit motive never interfered with the provision of quality care at ABC, he repeatedly acknowledged that it was a "balancing act." Indeed, it sounded as if Alex was walking a managed-care tightrope and that the slightest lapse of dedication could put quality care in jeopardy.

K: Are there things that you don't like?

A: I think that my toughest job is balancing, you know, we are for-profit. We do need to make a profit. Our profit margins are really small. You know, sometimes three to five percent. Most organizations probably would go out of business. They wouldn't stay in the

field if they're only making three to five percent. I think you need people that are really dedicated to the kids—to providing services—as opposed to making a profit.

To stay balanced, ABC maintains “small” profit margins. In addition, Alex told me “[m]ost of our money is reinvested into the company... [and] sometimes, we put more money into the company than what we take out.” Thus, according to Alex, ABC kept its pursuit of profit in check. However, the potential for priorities to slip appears to be great precisely because the profit margins are so small in this field. In particular, when people are not “dedicated to the kids,” Alex suggests that the pursuit of profit can trump the provision of care.

In addition to keeping the pursuit of profit to a minimum, Alex revealed that salaries for direct-care workers are also kept to a minimum. Although ABC considered paying its direct-care workers higher salaries, Alex revealed this would come at the cost of quality care. As Alex stated repeatedly, “it definitely is a balancing act between keeping the company afloat and providing the services.” According to Alex, “[w]e have the best ratios in the state: [we] have one staff per three kids. We could slash those numbers, give everybody a big raise, but then you're working two staff with eight kids.”

By having the best ratios in the state, ABC provides a higher quality service than what would normally be available. However, if the cost of providing that ratio is constant turnover, then high quality care is never actually achieved. According to Alex, although ABC's “philosophy is that, essentially, the kids come first, the staff come first. It's really difficult because . . . obviously, there's a lot of market trends you somewhat compete with.” That is, in the race to provide the most cost-efficient services, ABC has had to compete with other providers that keep costs down by paying their direct-care workers minimal salaries. In this competitive

managed-care marketplace, Alex reasoned that he had to keep salaries low in order to maintain high quality ratios. In other words, ABC was faced with a double-bind: provide high quality ratios with unsustainable salaries or provide higher pay with lower quality ratios.

While Alex acknowledged that sacrifices were made “trying to balance services with profit,” he indicated that those sacrifices tended to be in the area of “employee benefits.” That is, while Alex acknowledged that the pursuit of profit “conflicts with what we offer the staff,” he insisted that did not conflict with the quality of care that was provided. Although Alex was confident that ABC was balancing its cost-control mandate—through low pay—with the provision of quality care—through high quality ratios—his employees revealed that his company routinely fell into disarray as naturals were immensely underappreciated and impossible to retain.

#### The Hemorrhaging of Naturals

At Mountain View, the recruitment of naturals was based on random luck and their retention was impossible due to the combination of high stress and low pay. When Dylan described his job to his friends, he stated: “[y]ou know, they admire the job. They say ‘that’s pretty cool, you work with kids, but I would never ever want to work there. It sounds way too stressful and way too hard and you don’t get paid enough money for the work you do.’” In regards to his pay, Dylan reported in 2008 “after three months of working with the company, I made eight seventy-five.” Although David was getting paid “\$10.60,” he indicated “I had to fight, scratch, throw tantrums, raise holy hell to get that much. I mean, I’m a college graduate with a BS in history and a BS in criminal justice.” When I asked him if he felt underpaid, he stated “oh yeah! Ohhhh! Oh yeah! (laughing).” By way of comparison, he revealed “I was talking to one of my friends who delivers pizzas. She makes fourteen dollars an hour for delivering flippin pizzas.” He added, “I’ve been there for a while and I’ve moved up one level and got a sixty cent raise,

whooh-hoo! [sarcastic tone].” In Jimmy’s experience, “[t]he pay is not very good.” According to Lance, it was “not the best job” and explained that “[t]he pay isn’t the greatest.” When I asked Charlie what might explain the turnover, he replied: “probably the high stress: a lot of responsibility and a low amount of pay.” According to Krystal, “I don’t think there’s a money amount that you could put on . . . what we had to do and what we did. My life has pretty much changed because of the job, because of the last incident that I had: receiving a concussion . . . I don’t think any money can compensate for that. Just the way that we had to work, definitely, we were underpaid.” When I asked Krystal why she stayed on the job as long as she did, she reported “um, honestly, because of the boys . . . I promised the boys I would and they see so many staff members just get up and leave because they’ve had enough or burnout . . . or whatever it is . . . (long pause). So, with me it was . . . (pause). I basically wasn’t going to leave that job unless I had to and I had to because of the concussion.” According to Luna:

[I]f you want people that are top notch and give a damn about what they do, then you need to pay them. You need to pay them what their worth is, because then . . . they will go above and beyond for you and still be with you in the bad times, but also reap the benefits in the good times . . . [W]hen you do have really good people that care—and know what they’re doing—and they don’t get recognized for their abilities or get recognized for their commitment, then you’re opening up a Pandora’s box because then they’re going to be like, ‘well, why should I do that’ and there’s no amount of morale or incentives that can get even those people—from a manager’s point of view—into that top notch level of performance. There’s just no way, if the pay is not there.

When I asked Luna if she believed direct-care workers were underpaid, she replied: “absolutely. Underpaid, overworked . . . and then to have to deal with constant battling of the human psyche everyday... (pause) *draining*.” Frustrated, Luna stated that ABC had “absolutely no appreciation, no recognition for the ones that gave a damn.” In her experience, “you can only take so much when you have upper management that don’t care about them.” According to Daisy, “for a company where people come in there wanting to help kids, where your heart is actually guiding your decisions, it’s unacceptable because there’s a reason why people leave and it’s not because...(pause). I don’t think it’s necessarily because of the job . . . I’m guessing they don’t feel supported or they feel like they’re getting—you know—shit on and that’s a horrible thing to do because the job is difficult enough.” When I asked Daisy what she thought explained staff burnout, she replied “I would say lack of appreciation, lack of incentives . . . I think that you guys do an amazing job and you’re just not recognized enough for it and that’s very sad. And it’s a disservice.”

When ABC rolled the dice in its recruitment of a caring collective, it occasionally hauled in “amazing” direct-care workers who appeared to be naturals. These individuals possessed an interpersonal skill-set that was beyond the ordinary. In addition to having the ability to establish natural points of connection that were unforced and driven by reliable care, these practitioners also demonstrated emotional grit. Despite the rarity of this therapeutic skill-set, it was largely taken for granted by ABC. Although it was commonly recognized that these naturals had what works in practice, their skills were underappreciated and undervalued. Despite the effort that was put into hiring a caring collective, ABC was unable to retain those who had the necessary skills.

### The Constant Supply of Weak Staff

Because the retention of naturals was close to impossible, ABC routinely hired and held onto direct-care workers who were “sub-par.” In Dylan’s experience, “you can . . . continuously do sub-par work that harms the treatment program and not be fired and work here indefinitely.” Further, in his experience “the [group-home managers] know who their sub-par staff are, but they can’t afford to fire them because they can’t afford to work every hour of every week and that’s what would be required if we fired all our sub-par staff.” For example, Dylan indicated that there was a direct-care worker who had a college degree and “x amount of experience, but in actuality does not work very well with the kids. This gentleman didn’t care. He just did what he had to do without being inconvenienced. If he were to fail at something and there was no consequence, he wouldn’t care. If he were to fail at something and he would be called out or talked to, he would avoid that situation because it would just cause him more work in the end. So, whatever way he had to do the least work, he would do.” Despite having above average qualifications, this “gentleman” didn’t have what works in practice. Nevertheless, he was held onto because Mountain View was hemorrhaging close to 100% of its direct-care workers each year and was continuously in need of staff. When I asked Dylan if it was hard for Mountain View to find suitable replacements, he stated “well, I’m sure there would be replacements available if we were paid more.”

#### The Constraints of Cost-Control

When Alex started ABC, he wanted his company to stay “small” so he could have more control over the quality of care. True to this vision of higher quality care, Alex and his partner decided to “hand select” their “first batch of staff from [Sunbelt] University” and instituted the “best ratios” of direct-care workers to residents in the state. In those early stages, Alex and his partner “were focused on one home”—Mountain View—and they “hired ten people and it was

really our best group of staff we ever had and I think that a lot of that has to do with . . . our experience, being in the field.” Although one staff member “quit within the first month . . . the other nine stayed with us for about a year.”

However, instead of remaining “small” Alex told me how ABC quickly expanded from one group-home to seven, opening “a house every six months.” Ultimately, Alex saw expansion as “the only way to really improve benefits for the staff.” By expanding, ABC could purchase employee benefits in “volume” and achieve “economies with scale.” Rather than remain “more involved with daily operations,” Alex retracted himself from Mountain View and hired administrative staff to do the recruiting and training for his growing company. However, “things declined for us because we had people in these positions that really didn’t have the same level of experience.” In addition, he eventually decided “we won’t do another group-home . . . with the given set of resources we have . . .” because “it would really water down the quality.”

In hindsight, Alex realized that ABC’s growth had exceeded the pool of competent practitioners willing to work for low pay. Sadly, when ABC tried to improve benefits for staff through “economies with scale”—while remaining competitive with the “market trends”—it resulted in exposing the kids at Mountain View to a constant supply of weak staff who facilitated chaos instead of therapeutic relationships. Ultimately, ABC routinely granted workers unwarranted authority to work with troubled youth as the recruitment and retention of naturals was nearly impossible within the cost-control mandates of the state.

#### Industry-Level Chaos

When the state mandated that care be provided on the cheap (see Currie, 1997), it handcuffed the ability of people like Alex—regardless of profit motive—to recruit and retain quality workers. Moreover, Alex indicated that the issue ABC encountered was one that

“nationally, everybody struggles with.” Admittedly, Alex stated “I know people tend to pinpoint pay, which I do think is a factor,” but in his experience, the larger issue was that direct-care work is “not standardized.” As he put it:

There’s no certificate program. There’s no degree program. You know, I think that’s the biggest issue... [T]he company’s responsible for their own training and I’d like to see the universities do that, community colleges, you know: similar to a nursing program. We don’t have that standardized for direct-care.

Unlike the regular healthcare system in the US, the behavioral healthcare system doesn’t have a standard—certified process—for developing direct-care practitioners similar to nursing or nursing-aide programs. In his estimation, universities and colleges should be standardizing the qualifications of direct-care practitioners in the behavioral health field as is being done in the regular healthcare field.

Although the state regulates the educational requirements that are needed to become a behavioral healthcare practitioner, Alex realized these qualifications failed to supply him with competent workers. Given this predicament, Alex “started to realize that, okay, it’s not about recruiting qualified people, it’s about developing staff.” However, since “it takes a good six months to get a staff adequately trained . . . [w]ith our turnover rates, we never reach that...” Because direct-care practitioners only stick around for “a six month average,” by the time they’re adequately trained, they’re gone. Further, as revealed by Alex, “that’s not ABC specific. That’s really what the industry norm is.” Thus, not only is Alex operating within an industry norm that justifies paying direct-care workers very low wages—which makes the recruitment and retention of naturals nearly impossible—he’s also operating under a larger institutionalized norm that fails to invest in developing direct-care workers in the behavioral health field in the same way our



society develops direct-care workers in the regular healthcare system. In other words, cost-control appears to be prioritized over the provision of quality practitioners. If Alex is correct, organized chaos may be the industry norm.<sup>43</sup>

Nevertheless, companies like ABC can point to a *paper-trail of propriety* that demonstrates that the qualifications of their direct-care workers are inline with the standards of the state, that their training covers what is required, and that their pay is in accord with that of other providers. Further, by relying primarily on paper surveillance, the state also enables weak staff to cover their tracks.

For example, in Tina's role as a quality assurance manager, she reported that when she visited ABC's group-homes it was easy for staff to collude and "block wall . . . you know, 'oh, cover this, cover that'—you know—'don't write this down, we don't want Tina to know this'—you know." While Tina was frustrated by the practice of covering up substandard care in paperwork, David suggested that creating a paper-trail of propriety was actually pressured from above. As he put it, there was an expectation of "continuously covering your ass on each and every thing."<sup>44</sup> When I asked him how someone would cover his or her ass, he replied "um, paperwork, um, maybe you didn't handle the situation in the text book way and somebody is upset about it and is going to give you some sort of corrective action or is going to get angry and bring it up to a higher level authority." Although the threat of a "corrective action" may have been intended to ensure that staff are doing what they are supposed to be doing, David indicates that it can create an incentive to cover your tracks with "paperwork." While this paper trail

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<sup>43</sup> If Alex had it his way, "we'd like to have a certificate program where you have to be certified to offer these services in a program or, you know, two to four years experience is what we would like to have."

<sup>44</sup> Similarly, Rhodes (1991) noted that practitioners of an emergency psychiatric unit would often use paperwork to cover up what actually took place to appease the state.

allows weak staff to cover up the chaos they facilitate, it is the state that enables a paper-trail of propriety to be produced in the first place. By allowing providers like ABC to account for themselves via paperwork, the state permits them to continuously expose kids to incapable direct-care workers who facilitate chaos, cover their tracks with paperwork and evade criticism.

### Conclusion

At Mountain View, working with troubled youth was recognized as an extraordinarily difficult job. Indeed, it was generally understood that most people didn't have the necessary skill-set. Despite the recognition that emotional grit and consistent care were needed, upper management realized these qualities were difficult to find, even harder to train, and nearly impossible to retain. While it might seem obvious that companies like ABC should figure out how to recruit, develop, and retain the naturals in this field, Alex was faced with a set of priorities that militated against their retention. When the state prioritized cost-control over the provision of quality care, it not only enabled the provision of substandard care to the poor, it also made the provision of high quality care unsustainable. Expecting quality direct-care workers to endure this emotionally draining, physically dangerous, and extremely challenging work for barely livable wages was to expect the improbable. Faced with the impossibility of retaining naturals, ABC had to fill these incredibly difficult—and continuously vacant—positions with weak staff. As facilitators of chaos, weak staff continuously undermined the provision of care at this evidence-based group-home. Even when Mountain View had a core of competent workers—somewhere between 30 and 40%—they still had to face chaos that was organized by structures beyond their control.

Tragically, organized chaos is just one of the ways in which the state facilitated substandard care to the poor at Mountain View. In the following chapters, I will present

additional examples of slumcare and illustrate how they were perpetuated. In the process, I will also show how the state failed one of the most vulnerable groups in our society: Native American children.

## The Therapeutic Void

Within our borders, Native American communities are among the most isolated and unjustly treated (Brave Heart, et al., 2012; Crofoot & Harris, 2012; Davis, 2001; Deyhle, 1995; Eaglewoman, 2010; Goodkind, et al., 2010; Goodkind, et al., 2011; Jacobs, 2004; Lomawaima & McCarty, 2002; Snipp, 1992; Strickland, 1986). The intergenerational and community-level trauma associated with state violence, stolen resources, cultural genocide, racial stigma, and the provision of inept and culturally inappropriate services are well documented (Brave Heart, et al., 2011; Brave Heart, et al., 2012; Brave Heart-Jordan, 1995; Dionne, et al., 2009; Evans-Campbell, 2008; Gone, 2013, Goodkind, et al., 2010; Goodkind et al., 2011; Goodkind, 2012, Wiechelt, et al., 2012). Yet, the consequences of this unjust treatment remain largely out of sight and out of mind (Goodkind, et al., 2010). Despite the presumed windfall of casino cash flows, Native American communities across the country are struggling with some of the highest levels of unemployment, childhood poverty, educational inequities, violent victimization, and suicide (Brave Heart, et al., 2012; Davis, 2015, Duran, et al., 2004; Goodkind, et al. 2010; Goodkind, 2011; Logan, et al., 2012; Sarche & Spicer, 2008). Given the historical, social, and political roots of these community-level hardships, it has been suggested that “when examining the high rates of violence exposure, mental health challenges, and health inequities faced by American Indian youth, it is important to understand the context from which these inequities have emerged” (Goodkind, et al., 2012, p.1021). Further, it has been argued that the collective nature of

community-level trauma “cannot and should not be conceived of in terms of individual pathology” (p. 1022). Indeed, this trauma is increasingly being recognized as “collective, cumulative, and intergenerational” (Gone, 2009, p. 752). Given what is known about the links between trauma and the perpetuation of violence, it is vital that we begin to understand how collective trauma is linked to aggression within some of our most unjustly treated communities.

Nevertheless, most violence reduction interventions remain focused on the individual. In fact, programs like Mountain View narrow their focus on the individual to such a degree that the historical, social, and political context of the individual’s trauma, anger, and aggression become irrelevant. This erasure of history is important to understand not only because many of the residents at Mountain View were Native American but also because it implicates programs like Mountain View in the cumulative suffering produced by the state (see Farmer, 2004).

In this chapter, I will review some of the contemporary sources of community-level trauma in Native American communities and demonstrate how the state is implicated in the cycle of violence in these neglected places. Further, I will explore how generic behavioral programs—like Mountain View—place Native American children, their families, and their communities at risk of re-traumatization. Moreover, I will demonstrate how—despite the rehabilitative aim of the program—my colleagues encountered a disturbing therapeutic void at Mountain View.

### Collective Trauma

While the sources of collective trauma span multiple generations and vary from tribe to tribe, one of the more recent contributors to this community-level harm is the legacy of forced child removal during the Indian boarding school era (Gone, 2009; see Brave Heart et al., 2012; Davis, 2001; Evans-Campbell, 2008; Greenfeld, 2001; Jacobs, 2004). Although experiences in these schools varied, it was not uncommon for these children to be placed in “[d]eplorable

conditions” (Jacobs, 2004, p. 41; see Crofoot & Harris, 2012) and for staff members to use “brutal corporal punishment . . . against their wards, including sadistic acts of torture” (Gone, 2009, p. 752). A former matron of one these schools reported that in addition to seeing children being clubbed and dragged by their hair for ‘acting smart,’ “Hopi children were whipped or forced to carry heavy rocks as punishment for speaking their language” (Jacobs, 2004, pp. 40-41).

Tragically, Native American communities across the country are still struggling with the legacy of this institutional violence and the “multigenerational disruptions in parenting practices” it caused (Gone, 2009, p. 752; see Brave Heart, et al., 2012; Dionne, et al., 2009; Evans-Campbell, 2008; Goodkind, et al., 2011). Not only were many boarding school survivors “deprived of traditional parental role models,” their “boarding school experiences . . . [also] instilled new, negative behaviors” (Evans-Campbell, 2008, p. 326). In a 2007 study, for example, a Native American grandmother reported ‘I find myself yelling at my grandchildren because we were treated like that at boarding schools . . . My sister and I didn’t know anything about raising families because look at the way we were treated’ (Goodkind, et al., 2011, p. 460). Unfortunately, a number of scholars have identified “abusive boarding school experiences as factors contributing to the high rates of domestic violence and child maltreatment that exist in many tribal communities” (Brave Heart, 2012, p. S179). Although the literature linking adverse childhood experiences with the perpetuation of violence in adulthood is well established (Duke et al., 2010; Finkelhor et al., 2007; Smith & Thornberry, 1995; Widom, 1989), it is important to understand that many Native American communities have endured “collective adverse experiences” at the hands of the state (Brave Heart, 2012, p. S179). Forced child removal has not only been a “collective blow” to Native communities across the country (p. S179), it continues to

be a re-traumatizing and cumulative harm (Evans-Campbell, 2008). In a study conducted in 2000, a Lakota man reported:

Some of these things happening over the years are still happening today, like my grandparents, my great grandparents had their children moved to schools. . . . I was moved, my brothers and sisters moved. . . . There's a big hole in my heart. We see it happening to our grandchildren already . . . Where does it stop? (Brave Heart, 2012, p. S179).

Although the U.S. has officially abandoned its policy of cultural genocide, abusive treatment in boarding schools continues to be documented (Crofoot & Harris, 2012, citing Hinkle, 2003). In addition, Native American children continue to be forcibly removed from their families by child welfare agencies in disproportionate numbers (Bussey & Lucero, 2013; Carter, 2009; Crofoot & Harris, 2012). For example, in a nationally representative study of child welfare placements, it was found that although “alcohol abuse and a family's inability to meet basic needs were more prevalent among non-Indian caregivers,” Native American children were “eight times more likely to be removed from their homes” when a caregiver had an alcohol problem and “three times more likely to be placed” out-of-home when their caregiver had problems providing for basic needs (Carter, 2009, pp. 844-845). Further, although there was no significant difference in reports of physical neglect between Native and non-Native families in the study, Native children were “four times more likely to be removed from their families because of physical neglect” (p. 844).

In 1978, the Indian Child Welfare Act (ICWA) was intended to rectify the disproportionate removal of Native American children and to keep Native families intact. However, progress has been hindered by widespread non-compliance with the ICWA and the

underfunding of culturally appropriate child welfare services for Native Americans (Crofoot & Harris, 2012). These documented failures include failing to place children with Native families and “placing children in more restrictive placements (group care) instead of least restrictive placements” (Crofoot & Harris, 2012, p. 1671). Given the legacy of forced child removal and the persistence of disproportionate child removal, it has been argued that there is a “need for CPS workers to see family preservation as a social justice issue” for Native Americans (Bussey & Lucero, 2013, p. 396).

From an “Indian Child Welfare perspective,” Crofoot and Harris (2012) argue that “challenging child welfare systems . . . is the first step in reducing disparities” (p. 1672). In addition, they argue there is an urgent need to provide culturally appropriate services that value the “interdependence of extended family . . . and the esteemed role of tribal elders in leadership, discipline, and spiritual guidance” in Native American communities (p.1672). Moreover, these services should be “home-based,” provided by Native American case workers, include “traditional Indian therapies,” and involve Native American foster parents when necessary (p. 1672).

Although the provision of culturally inappropriate services has been critiqued extensively at the policy level (Brave Heart, et al., 2011; Goodkind, et al., 2010), there is still a need to understand how the provision of such services is experienced in practice. In fact, the lack of inclusion of Native Americans in the evidence-base of many evidence-based interventions for youth raises valid concerns about the appropriateness of such interventions (Goodkind, et al., 2010) and amplifies the need to understand how the provision of these interventions are experienced. Given what is known about the community-level trauma in Native American communities, the potential for unnecessary child removal to be re-traumatizing, and the



cumulative harm that can be caused by providing culturally inappropriate care, the need to examine how these interventions are experienced is paramount.

### The Unexamined

During the year and a half I worked at Mountain View, anywhere from fifty to seventy-five percent of the kids were Native American. More often than not, these kids were placed at Mountain View by child welfare caseworkers. In addition, the vast majority of these adolescents came from reservation communities that were approximately 100 miles away.

According to Dylan—the program coordinator—the kids at Mountain View were “almost always referred through a case manager. Like, we’d often times have a case manager sending two or three [kids].” He explained:

Most were referred through contacts with [Luna]. She would meet case managers and agencies . . . [and] she’d give out the basic information of our house: ‘we focus on anger management, we have mostly Native American boys.’ Our [group-home manager] is Native American and these case managers would get . . . this information and go ‘well Johnny has anger problems and he’s Native American and his anger problems . . . matches the level of this facility, so let me call up [Luna]’

When I asked Dylan how often kids were referred by these agencies, he reported “four out of five times, it’s an agency.” When I asked Dylan why these agencies were involved, he indicated “a lot of times an incident requires them to be involved, such as fighting on a school bus—you know—that requires an investigation of how they’re supervising their kids or telling them to behave (pause) and they go into the house and find neglect. Some cases, the children, they have no family and they’re having trouble within that foster care or just within their CPS [child protective services] system, so they’re sent here to have those behaviors reduced.” When I

asked Dylan how often the kids at Mountain View had child protective services caseworkers, he reported “most of our boys do.”

According to Beth—a seasoned direct-care worker who worked with about forty kids during her time at Mountain View—“each and every kid” had a history of maltreatment. When I asked Don—another seasoned direct-care worker—what percentage of the kids he thought had maltreatment histories, he would report “one hundred percent... I think all of them.” When I asked Tina—the regional manager—she indicated “over ninety percent of the kids that we serve have had some form of abuse, neglect in their history.” When I asked the CEO, he responded, “[I]et me put it this way, if we only took kids that were not abused, it would be a small percentage of the kids we have now... it’s hard for me to come up with a number that weren’t.”

As Tina described it:

[For] most of the residents, what will happen is they’re taken away [by] CPS—most of the residents—taken away from their biological parents due to neglect or abuse. From there, I’d like to believe the state usually tries to place a child in a foster placement ... What usually happens from there is that the child will blow out of the foster placement based on their behaviors or, same thing with parents at home, you know, mom—single mom—not able to control the kid . . . usually it’s oppositional defiant, some kind of aggression that the parents just don’t know how to deal with, or foster parents don’t know how to deal with . . . they may even try another foster placement just hoping that maybe it was just the foster home... If that then fails, the kid will either end up in juvenile, their behaviors will increase, which will cause a CPS worker to usually look at a [Level B], which is a residential treatment program.

As a Level B treatment facility, Mountain View’s mission is to examine, scrutinize, and treat problematic behaviors away from the child’s home. In addition, Mountain View utilizes a non-Native perspective on behavioral problems that is entirely taken-for-granted. Indeed, to qualify for services at Mountain View, adolescents must have diagnosed behavioral problems that not only impose upon these youth individualized conceptions of pathology, but also ignores how the abusive treatment of Native American communities across multiple generations is connected to their present-day trauma and aggression. While the kids’ diagnoses varied from conduct disorder, to oppositional defiant disorder, to attention deficit hyperactivity disorder, the one thing most of these kids had in common—but was largely unexamined—was their underlying trauma and how it was linked to the collective trauma in their communities.<sup>45</sup>

Although it is well documented that the Native American communities most of these kids came from are dealing with the violent legacies of Indian boarding schools and the continued removal of their children into culturally inappropriate placements, these kids were sent to Mountain View to have their behaviors corrected by mostly non-Native practitioners; thereby putting these children, their families, and their communities at risk of re-traumatization as yet another generation of Native American children were being told how to behave by the same group of people who disrupted their families and entire way of life.

Although Mountain View’s generic—evidence-based—behavioral design failed to address collective—intergenerational—trauma, the understanding that most of the kids experienced trauma as a result of the distressed environments they came from was quite universal among the staff. In addition, this experiential knowledge even went so far as to trump

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<sup>45</sup> Similarly, in a study of mental health workers in a maximum security prison, Rhodes (2004) noted that “despite the culturally supported assumption of a transparent relationship between past and present, no single technique connects traumatic experiences and current motivations” (p. 125). Instead, practitioners tended to focus narrowly on “daily speech and behavior.”

biological and diagnostic-based explanations of their aggressive behaviors. As Alex explained, “I think their diagnoses definitely play a part . . . but there are plenty of kids with ADHD and PTSD that don’t display these behaviors. So, I do think that a lot of it has to do with their environment.” Similarly, Luna would tell me “I don’t believe that kids are born bad . . . I think a lot of it is environmental factors that really exacerbate everything that may have been mild at one point.” According to Tina, even when kids are “making bad choices . . . when you look deeper into those cases, something is not right at home.” As Gary put it, “[t]hese kids are angry because their lives have not been good . . .” Frustrated, Alex would tell me, “[u]gghh, I don’t think there’s any kind of empirical evidence that these kids have some of these diagnoses, but I think that a lot of times these kids were neglected, abused: emotionally, physically, sexually. I think—[for] a lot of these kids—their problems arise because of a situation at home.” Thus, while Mountain View’s treatment was focused on examining and fixing behaviors, its practitioners would become aware of underlying trauma that was linked to environmental distress. Nevertheless, this knowledge would remain largely unexamined: it would become the neglected focus of treatment.<sup>46</sup>

While it would be accurate to note that Mountain View’s generic behavioral design ignores the sources of “multiple disadvantage” within reservation communities and makes adolescents responsible for managing those disadvantages with behavioral skills (see Muncie, 2006: 778), it would not be accurate to say its practitioners are completely unaware of the disadvantages these kids face. Indeed, when the attention given to behavior was coupled with inattention to environmental distress and trauma, it produced a peculiar sense of program efficacy at Mountain View. In a curious display of cognitive dissonance, practitioners held onto a

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<sup>46</sup> Similarly, Currie (2012), Carlen (2008), Hannah-Moffat (2008) and Gray (2005) have also noted how contemporary interventions tend to neglect the social and environmental contexts of offenders: both in terms of how they are implicated in their initial offending and in terms of how they will affect their eventual return home.

firm belief that behavioral treatment worked while simultaneously holding onto the belief that it would all unravel as soon as these kids went home. This disconnect not only demonstrated how ephemeral and illusory the entire therapeutic enterprise was at Mountain View, but also how misguided it was to focus narrowly on behaviors when it was known that most of these kids would return to distressed environments dealing with community-level trauma.

### Program Denial

Ken: What do you understand as the primary goal of the company?

Beth: The primary goal . . . should be to teach the kids alternative behaviors.

They are successful to a certain point, but... I think the parents are the ones that should really be involved with the company. I think the company should teach the parents how to work with their own kids... Because, once [the kids] leave here, they go back to the way their behavior was before...

When I interviewed Beth and our fellow colleagues at Mountain View, it became clear that behavioral change was more complex than advertised. In addition, the possibility of sustained behavioral change was quite suspect. In fact, many of our co-workers were haunted by a sense that although kids could make therapeutic gains while under ABC's care—albeit, in unrecognized ways—all would be lost as soon as the kids went back to their real homes. Nevertheless, everyone went about their business as if we were fulfilling our mission of fixing kids. I found this insight to be both perplexing and disturbing. To use a crude analogy, if we were car mechanics this would be akin to saying “we can fix your car; the only problem is it'll break down as soon as you drive it home.” Indeed, Beth's assessment that the program was “successful to a certain point” begs the question of how someone can see success in the face of failure. What prevents Beth from saying the program does not work? Ultimately, there was a

peculiar sense of program efficacy at Mountain View. I call this strange phenomenon program denial: that is, the inability to acknowledge a program isn't working despite inevitable failure. At Mountain View, program denial was clearly evident among my colleagues as they simultaneously expressed an inflated sense of efficacy and foreseeable failure.

### Inflated Efficacy

When I interviewed my colleagues, there appeared to be a high degree of confidence that behavioral change can be achieved. For instance, Mountain View's therapist—Daisy—asserted: “you can cure behaviors, you can stop behaviors, you can modify behavior.” Mountain View's recruiter/trainer—Gary—declared: “behavior can be changed, because we know that.” Alex—the CEO—went so far as to say: “a lot of times we can work on the child pretty quickly...” Indeed, this high degree of confidence could be interpreted as therapeutic swagger. However, this confidence wasn't merely based on theoretical possibility; it was also based on lived experience. As Luna—Mountain View's manager—explained:

I've seen a lot of behaviors changing: the boys actually grasping an alternative behavior other than going to a physical extreme or any other extremes that weren't recognized as normal. And, when you're seeing that day in and day out for twelve . . . hours a day and they can actually converse with you without screaming, without doing any hitting and all of that, that is gradual change.

Thus, behavioral change wasn't merely rhetoric at ABC; it was also a lived-experience. These practitioners knew kids could change because they saw kids improving. In other words, behavioral change wasn't just a goal; it was being accomplished. In fact, ABC appears to be quite successful at this business of behavioral change. According to Alex, ABC has a “seventy percent success rate: meaning that when kids leave us, they go to [a] lower level of care...”

Similarly, Daisy indicated that “the majority of the kids we’ve had have had successful discharges...” However, Daisy also foresaw failure when she envisioned these kids being successfully discharged home.

#### Foreseeable Failure

At Mountain View, it was quite common to hear an inflated sense of efficacy in one breath followed by foreseeable failure in the next. Indeed, there was a pervasive dread—a haunting sense—that all would unravel when kids were successfully discharged to their families. According to Daisy, when “the kids go home . . . they’re put in the same environments that created the behaviors and the behaviors are fixable. I mean, a couple meds here and there and some good reinforcements and some good structure and they’re fixable, but then they go home to the same thing and they fall...” At another point in her interview, she would reveal “it’s horrible to see the kid . . . improve their own behaviors only to have to go back to the same environment...” Similarly, Luna would lament “all we were doing was putting a band aid on it and not really fixing the problem because we could fix a kid and then send them back into what: a dysfunctional family? That was defeating the purpose.” When Mountain View’s regional manager—Tina—was telling me how the goal of ABC was to help the kids “return home” she would vent:

My problem with that, Ken, and I’ll continue to have a problem with that . . . is you can fix the child and place them into dys... (frustrated pause). You fix the child and then send them back into dysfunction. Agggghh... That doesn’t make sense to me.

Regardless of whether behavioral change is viewed as a therapeutic or “conformist” outcome (see Currie, 2012, p. 16), it is clear that the kids at Mountain View were changing their behaviors. Indeed, many of my colleagues believed that behavioral problems were fixable. Yet,

my colleagues also anticipated that these fixable behaviors would become unfixed as soon as these kids were discharged back into “dysfunctional” environments. Although the common belief that “you can fix the child” was dissonant with foreseeable failure, these contradictory views never led to the conclusion that this behavioral program did not work. Instead, practitioners held onto these contradictory assessments as if they could both be true at the same time. Tina, for example, held onto the belief that behaviors are fixable while also believing that a successful discharge into a dysfunctional environment made no sense.

If foreseeable failure were merely an expression of dread, that might explain why Mountain View’s practitioners wouldn’t acknowledge that the program didn’t work. However, like the experience of behavioral change, foreseeable failure was also grounded in lived-experience. According to Daisy, “there is a bounce back rate with the kids. I’ve seen kids’ names on rosters that have supposedly graduated from the program two or three times. I see some that aged out of the program and now they’re back for adult services and in my opinion that’s . . . not a success if they have to come back.” Even though Daisy witnessed a “bounce back rate” and concluded that it was evidence of unsuccessful outcomes, she still maintained an inflated sense of efficacy. Like many of my colleagues, this experience did not prevent her from declaring that “behaviors are fixable.” Indeed, the contradictory experiences of fixing kids and seeing them “bounce back” into the program—experiencing both success and failure—appeared to be impervious to resolution at Mountain View. Although experiencing failure could lead practitioners to conclude that generic behavioral interventions do not work, that wasn’t the case here. Instead, what practitioners revealed was program denial. Their sense of efficacy remained inflated in spite of foreseeing—and experiencing—inevitable failure.



When I asked Dylan if ABC did a good job dealing with the kids' behavioral problems, he answered "I think if there's no deep underlying issues, yeah, because that's something that can be helped just strictly through direct-care staff. We provide an immediate consequence, an immediate reaction . . . but I worry that most of the kids would regress if there's not adequate intervention with the family." When I asked Tina if ABC provides a service, she responded "really, are we providing a service? . . . Because we can fix the child and work with the child . . . but even if it is successful, it's kind of like planting a seed in bad soil." Although program denial militated against acknowledging that behavioral problems could not be fixed with generic behavioral interventions, practitioners were still able to provide insights as to why failure was foreseeable. According to Dylan and Tina, failure was foreseeable because fixing behaviors doesn't address the source of behavioral problems. In Dylan's experience, the source is embedded in "deep underlying issues" that are connected to the family. In Tina's experience, the source is in the dysfunctional environments they come from; what she refers to as "bad soil."

Ultimately, as revealed by Dylan, there is something in the immediacy of behavioral treatment that helps inflate a sense of efficacy. A sense of competence appears to develop in the delivery of "an immediate reaction" to behavior. As long as the close examination of behavior can proceed, behavior can be changed through immediate responses. As Jimmy confidently put it, "we are teaching them positive behaviors." In Tina's words, "we can fix the child." In this manner, the examined—the focus of generic behavioral treatment—helps inflate a sense of program efficacy.<sup>47</sup> However, in Dylan's experience, that is only so long as there are "no deep

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<sup>47</sup> Extending Foucault's (1977) discussion of the *examination*, I offer the concept of the *examined* as the specific focus of examination techniques. Indeed, hierarchical observations and normalizing gazes—examination techniques outlined by Foucault—were instituted at Mountain View. However, the behavioral focus of these observations and normalizing gazes were so narrow and so specific that the knowledge they produced ultimately revealed their disciplinary

underlying issues.” Because most of Mountain View’s kids—in Dylan’s experience—have underlying issues, he foresees failure when these kids are deemed ready to return home. That is, recognition of the unexamined leads to foreseeable failure. Although the contradictory implications of the examined and the unexamined never led to the complete resolution of program denial, the tension and frustration they produced did lead to valuable insights that help explain why failure was inevitable.

### Experiencing the Void

When I asked Krystal if ABC did a good job dealing with the kids’ issues of abuse and neglect, she responded “honestly, no. I don’t think so.” When I asked Beth how the company dealt with these issues, she simply stated “it doesn’t.” According to Dylan:

We’re trained to deescalate. We’re not trained . . . in a more therapeutic way of how he’s really gonna get better. We can help them for the moment so they don’t injure themselves or someone else, but as far as continually addressing these issues . . . [w]e are not trained to do that at all.

At Mountain View, direct-care practitioners were trained to scrutinize and provide immediate responses to behaviors. However, in the process of providing that trained response, they would become haunted by abuse, neglect, and abandonment “issues” they weren’t prepared to deal with. This therapeutic void was not only evident in their everyday practice, it was also tormenting. As Don put it:

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limits. That is, when the unexamined was acknowledged, it produced an understanding that the focus of the examined was not sufficient to produce lasting change. In other words, behavioral examination was insufficient.

I wasn't trained to respond... I need to be able to respond when somebody says, you know, 'I hate myself and I'm going to hurt myself' . . . how do you respond . . .? They need something right then and there . . . I was not trained to respond to those statements.

In other words, Don saw a difference between the behaviors he was trained to respond to and the traumatic statements that would often underlie them. Although Don felt adequately trained to restrain an adolescent who was trying to hurt himself, he didn't know how to deal with the statements that gave those behaviors meaning. Similarly, Jimmy explained that when a kid becomes aggressive, "all [staff] see is the surface behavior and then they put him in a hold, give him some medications or basically tell him a strategy without really addressing . . . 'what are you pissed off about . . .?; you know.'" Similar to Don, Jimmy would note a difference between teaching a kid positive behaviors and addressing his "problems."<sup>48</sup> Nevertheless, it was his understanding that "we don't delve into those issues."<sup>49</sup>

According to Charlie, "when you start getting into that, then they get really upset and it takes a higher level of care and sometimes it was too much for me." When I asked Charlie if he was trained to deal with the maltreatment issues the kids had, his short and poignant answer was "no." Likewise, Dylan's answer was also "no." While David's answer was—as well—"no," he added "for that, you usually fly by the seat of your pants." Because these adolescents routinely

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<sup>48</sup> When I asked Jimmy what he meant by "problems" he replied: "they may not understand that being a victim of abuse would cause them to be more aggressive."

<sup>49</sup> While the micro-physics of examination techniques function like a "microscope of conduct" (Foucault, 1977, p. 173) which converts the child into an "individualized" case (pp. 192-193), it fails to examine the macro-conditions that produce collective suffering and trauma. As noted by Foucault (1965), when civilization moved "from a world of Censure to a universe of Judgment," madness not only became something that was judged, it became something that was "judged only by its acts... All the rest is reduced to silence" (p. 250). Indeed, while the production of psychological knowledge serves to objectify and individualize madness, the "experience of madness remains silent" (p. xii). At Mountain View, the silencing of collective trauma not only haunted practitioners because they knew the program was failing to address what these kids were experiencing, it also led to foreseeable failure.

had no trained practitioner to talk to about these issues, Beth referred to this as “being left out in the cold.”

According to Krystal, care had limits at Mountain View. In her words, “you’d have to really care about the kids enough to hire well-enough staff as well as train the staff properly.” In her opinion, “taking care of [the kids]” meant “understanding each boy and why they’re there: their backgrounds of abuse and everything.” Although some direct-care staff were better than others in the way they responded to these issues, Krystal indicated there was “no trained answer. Everybody would respond differently...” In fact, some would respond by simply ignoring or pushing these issues aside. As David divulged, “I . . . try not to delve too deeply into it, because I’m not a trained therapist and don’t want to do more harm than good...” My conversation with Charlie revealed a similar response.

Ken:           Were you ever in a position where some of the kids came forward about some of their abuse issues?

Charlie:       Yes, sometimes I’d be sitting down with one of them and they’d mention it. I’d kind of ignore it, push past it.

At Mountain View, trauma was known yet neglected. By design, the adolescents were treated mostly by direct-care staff: that is, behavioral healthcare practitioners who were neither qualified nor trained to deal with issues of abuse, neglect, and abandonment. Ironically, the kids at Mountain View were being taught to manage their trauma with behavioral skills that ignored that trauma. When the program was operating as intended, the kids would see a licensed therapist individually for one hour a week. However, when these juveniles needed a therapeutic response for their issues outside of that hour—which was quite often—there was no trained response. For the overwhelming majority of their time at Mountain View, these kids encountered a therapeutic

void. Ultimately, not only was this generic behavioral program ill-equipped to address collective—intergenerational—trauma, it was also ill-suited to address trauma at the individual level. In fact, it was largely designed to ignore it.

### Therapeutic Misalignment

Within this void, Mountain View’s practitioners came to see *therapeutic misalignment* as a major reason why it existed. As revealed by Beth and Dylan, their experiences with foreseeable failure were primarily based on the lack of intervention with families. However, they were not alone in this experience. When I asked Don if the program worked with families, he replied “[n]o, we don’t (long pause). We don’t. We should.” Echoing his sentiment, Krystal told me “I’m not aware of it. I don’t think so.” In her experience, the kids would “get a phone call . . . once a week.” Although she was aware that Mountain View had Child and Family Team (CFT) meetings, she reported “the family I don’t think ever showed up. I think it was always on the phone.” Similarly, Beth stated “it would be nice if the company would work with families. I think the only time I know that the company talks to the families is during the CFT.”

According to ABC’s program documents, the therapist is expected to provide the boys with family therapy as needed. However, Krystal told me “never did I have a boy leave during my shift to go next door to have family therapy.” Likewise, Gary also never saw family therapy take place. In Tina’s experience, “I know with a lot of our residents, because they’re Native American, they live on the reservations and transportation can be a huge issue as well as phone conferences, which I know has been a challenge for lots of different areas in the past. We do offer family therapy. Have I ever known that to take place? No.”

When I asked Dylan if the program was designed to work with families, he responded “yes, it’s designed to, but it rarely happens. I’ve been in child-family teams where we have

lawyers . . . and . . . they asked me what's ABC's position and I'd say 'well, he's progressing fine at our house, he's doing fine, the biggest issue is family therapy' and that gets put on the agenda, but never actually happens.'" When I probed further as to why family therapy wasn't occurring, Dylan reported:

[F]or us, you have families that live way out on the res, that are poor, that travel a lot of time to even come here in the first place and they can't commute to our facility to do frequent, common, regular family sessions with the child, with the therapist, and with ABC . . . If it's gonna work you would have to work . . . with the family's schedule. Take the kid, take a therapist, and drive out to their house.

When I asked him if the company could do that, he replied "I'd say it's possible. It's definitely possible, but I don't think it's within their mandate. It's an area where they don't have to do it, so it most likely won't happen. You would need a therapist that would really want to go—be going the extra mile—and you need a company that would say 'sure, I don't care about the gas prices, drive this company car five hundred miles' . . ."

According to Luna, Daisy "had family therapy, that I know of. . . (long pause) with three boys the entire time that I was there and of those three boys . . . many complaints arose . . . and the biggest thing that I always heard *consistently* [from reservation parents] was she doesn't know what she's doing . . . So, therefore, they thought it was a waste of their time and a lot of them had to come in ninety miles away, a hundred miles away, just to have that family therapy and no way would she ever make that effort to say 'well, how about if I go into your environment. How about if we can do that.' Because, she would say contractually she doesn't have to do that."

When I interviewed Daisy and we talked about the kids' behavioral problems, she told me "it's the parents that are the biggest problem because they don't do the family therapy . . . I just don't see a lot of... (long pause). I see next to no family involvement and it's been that way since I've been here." When I asked her about family therapy, she stated "I would love to do more family therapy . . . I have pushed for that. I have contacted families. I have contacted parents. I've contacted case managers. I had set up appointments. I have been brutally shot down many times [by the parents] for family therapy and I think that should be a stipulation of having a resident here. That should be part of the paperwork and the contract. If your child comes here for treatment, family therapy will be required . . . I've heard every excuse imaginable: *every excuse imaginable*." As Daisy went on to describe an example of a dad who repeatedly missed appointments and how she would "pull up my clinical notes and . . . put refusal and . . . put direct quotes in them," at no point did she ever mention the distance Native American families would have to travel or the financial strain it would put on them to make appointments at Mountain View. Nor did she ever mention cultural differences as an issue.

Although Mountain View was designed to provide family therapy in addition to its behavioral program, it rarely occurred. According to Luna and Dylan, Daisy could have provided more therapy if she were willing to go "the extra mile" for Native American families on the reservations. While it may have been unreasonable to expect Daisy to travel hundreds of miles to provide family therapy on a regular basis, it begs the question of why ABC was permitted to place these kids so far from home; especially since the ICWA calls for placement "within reasonable proximity to his or her home" (Indian Child Welfare Act of 1978: § 1915 (b)).

Ultimately, the provision of family therapy at Mountain View appears to have been nothing more than an empty gesture by ABC as it was known that transportation issues were

enormous obstacles for reservation families. While it is debatable whether Daisy did all she could do to provide family therapy, it is clear that ABC prioritized behavioral correction over family involvement when it placed reservation kids 100 miles away from their homes. Moreover, it is clear that child welfare services were complicit in the lack of family involvement. As Beth told me, “[h]onestly speaking, the social service from the Bear reservation will not teach the parents anything. They take the kids and then the kids become part of the state: custody. And then after that, the parents are forgotten until something happens to the kid, and then the parents are brought back in and they really don’t have that follow through with the parents... It’s one of the problems with the Bear reservation: that the social services are not really involved with the parents after they take custody of the kids.”

When I asked Luna who was responsible for ensuring family involvement, she told me “I think that it was a combination of both our responsibility—in terms of the company—but as well as . . . [the] case workers to include that family . . . I think it was probably part of my job to address that at CFTs . . . to push for that... On the case manager’s side . . . they should say family therapy should have been a must.” However, as revealed by Dylan, Luna, and Daisy, there was no contractual mandate to do so even though the ICWA makes it clear that family preservation is a priority for Native American youth.

### Cultural Incompetence

As a licensed therapist, Daisy had the necessary credentials to conduct therapy during the hour she had with the kids. Nevertheless, her colleagues experienced her as being incompetent with our Native American youth. For example, when I asked Dylan if there were any weaknesses with Mountain View’s program, he honed in on therapy and concluded that the therapy Daisy provided was “nonexistent: not just a weakness.” He explained that Daisy “rarely meets with the



boys. When she does meet, she has virtually no rapport.”<sup>50</sup> Likewise, Luna’s assessment was less than praiseworthy:

I don’t think the therapist had any clue as to what she was doing and I have been in the business for many years and she is the worst therapist I have ever encountered, ever... There was no connection.

In fact, Daisy’s inability to connect and establish a rapport with the kids was repeatedly brought up in my interviews. For instance, Krystal told me “the boys didn’t really like the therapist, so a lot of them wouldn’t open up to her...” She also heard the kids say that Daisy “didn’t listen.” As Luna put it “the main complaint [from the kids] is she just never listened and they *felt* she didn’t care.” According to David, “the kids don’t trust the therapist at all... [and some] have just flat out refused to see her.” Frustrated, he disclosed: “I’ve asked the therapist ‘aren’t you supposed to do something about this?’ And she’s replied ‘I can’t make the kid talk.’ ‘Well, can’t you... I don’t know (sarcastic tone), motivate them, give them something shiny, give them a treat, uh, do something to get the kids to talk to you a little bit...?’ And I’ve never really seen . . . it happen.” Beth told me that when she would ask the boys how therapy went, a frequent reply was: ‘uh, we didn’t say nothing. I can’t talk to her’ or ‘It was boring, so I just fell asleep.’ In fact, when Beth would file away Daisy’s therapy notes, she would experience such a mismatch between what the children had revealed to her and what was in the notes that she thought Daisy’s “paperwork . . . [was] just made up.” In Dylan’s experience, “the boys I’ve worked with . . . did not like our therapist. They were adamant about their distrust and there can

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<sup>50</sup> After I collected my third interview for this study, I wrote in my research journal: “[i]n all three, it was mentioned that more therapy was needed. In each case the interviewees revealed this completely on their own. This bolsters my own personal/insider view that the home therapist doesn’t meet with the residents enough and doesn’t seem interested in building sincere rapports.”

be no therapy if there's no trust." Like Krystal, Luna, David, and Beth, Dylan also frequently heard complaints from the kids:

Some of them didn't believe she really cared. They didn't understand why they were going over to this lady's office for thirty minutes, once or twice every two weeks, because they wouldn't do anything that they saw connected with their life... 'it's like a waste of my time' was the attitude from the kids.

For some reason, Daisy's credentials failed to guarantee that she was capable of making the most basic human connections needed to establish a therapeutic relationship. In Gary's experience, "the therapist has to be someone who has the capability of being liked, accepted, appreciated and trusted..." As he saw it, a group-home needs to "have a therapist who wants to do this instead of does it because they've got a master's degree..." Although he would never directly implicate Daisy, he made it clear that in his opinion "there are some people with degrees that probably don't deserve them..." The key, according to Gary, was "to have a desire to be involved... If you can't find some way to get to the client, then you're failing..." After my interview with Alex, I wrote in my research journal that "when I discussed my concerns about therapy, he acknowledged that he had consistently heard that the house therapist had a poor rapport with the residents" (Journal Notes).

Based on the experiences of my colleagues, there are therapists who—despite having the proper credentials—fail at establishing therapeutic relationships. Nevertheless, they are able to falsely present themselves as competent in their paperwork. Although these therapists are properly certified, they are—nonetheless—nothing more than counterfeit therapists: competent on paper, yet complete failures in practice. While Daisy's incompetence may have something to do with her as a person, it may have also been inappropriate for ABC to assume that state

licensure guaranteed that a therapist could establish therapeutic relationships with Native American youth. In addition, it begs the question of why the state believed it was appropriate for Native American youth to be treated by non-Native practitioners who weren't trained to provide culturally appropriate interventions. Indeed, as revealed by my Native American colleagues, Mountain View was not a "program suitable to meet the Indian child's needs" (ICWA: § 1915 (b) (iv)).

For instance, in Beth's experience as a member of the Bear Tribe, "Native American kids . . . don't open up easily. They don't open up as easily as a white kid would..." Thus, she reported that for a non-Native practitioner "I think it's easier to get through [to] a white kid than a Native American kid." When I asked why that might be, Beth indicated that in her experience, Native American kids are "taught not to talk about anything" and "not to talk to strangers about your problems . . . because your problem is nobody else's problem... You need to learn how to deal with life . . . You need to learn how to be tough . . . without crying, without begging for anything . . . [Y]ou have to learn how to deal with your anger and your emotions. You can't cry in front of other people. That's bad luck... So, it's hard for the Native American kid to come in here—if they're taught like that—just to open up to you. It takes a lot of trust and a lot of work just to get there . . . So here, it's very natural for you guys not to really get close to them" (see Weaver & White, 1997)

In addition, Luna—who identifies as half-Eagle—indicated that the cultural distance between Native American kids and non-Native practitioners can be stressful for the kids. As she put it, "when you have kids that are coming straight off the reservation and they're put into something they've never known before, that just adds to their stress. That just adds to their behavior." Further, she noted that these kids are encountering "a whole different genre of what is

expected of them [and] they're going to continually want to act out if we don't understand where they're coming from." When I asked Luna what was different for these kids, she replied "something that we all take for granted: communication. Some Natives can't look at somebody in the eye when they talk because it's disrespectful. Other people may not know that. Something so simplistic like that—that people think is rude—is not rude the other way, and if you don't know that, things like that—as little as people think that they are—that's huge" (see Weaver & White, 1997).

Although Beth and Luna provided the kids with a degree of cultural competence at Mountain View, they believed it was insufficient. Not only were they aware of the cultural distance between the Native American youth and most of Mountain View's staff, but also that it would take a lot of understanding and trust to overcome that distance. Further, Luna indicated that she had hoped ABC would establish group-homes on the reservations instead of exposing these kids to culture shock and cultural misunderstandings. Poignantly, Don—who is a member of the Badger Tribe—stated "I've seen a lot of Native American kids [at Mountain View] and [the staff] should have the knowledge of Native American culture, or that particular ethnic group, like the Bear Tribe." Although Don was not a member of the Bear Tribe, he knew that "clanship" was very important to the Bear Tribe and he knew how important it was to introduce yourself according to your lineage (see Weaver & White, 1997).

Indeed, Native American Tribes have unique cultures and should not be treated as a homogenous group. In fact, Alex referred to the cultural diversity among Native Americans as an unexpected challenge. As he put it, "here, we deal much more with tribes. Culturally, there's a huge difference with the populations. I think that was our biggest challenge—to find something that was culturally sensitive to the Native American populations. Also, not understanding that the

Badger Tribe is much different than the Bear or the Eagle. It's not something that we expected. Just complete ignorance.”

While it is refreshing that Alex admits to cultural “ignorance,” it calls into question why ABC assumed its generic approach would be appropriate for Native American youth.<sup>51</sup> It also begs the question of how widespread this ignorance is. In a troubling, yet revealing, moment, Daisy informed me of how staff “get trained on cultural diversity” at Mountain View and dismissively added “I don’t know why. I’m not going to go into it. Wait till that’s turned off and then I’ll unload.” Although I never did come back to the subject after the recorder was turned off, her dismissive tone and need to “unload” suggested that Daisy was not a fan—to say the least—of cultural diversity training.

Clearly, Daisy is not representative of all licensed therapists. However, her dismissiveness of cultural diversity speaks volumes about the degree to which cultural incompetence was allowed to amplify the therapeutic void at Mountain View. In addition, it calls into question the decision of the state to sanction the use of generic behavioral treatment with Native American youth. Indeed, while Alex, Daisy, my non-Native direct-care colleagues, and myself may have been ignorant about the cultural diversity among Native American communities, that ignorance was enabled by the state and its unquestioned faith in generic behavioral treatment.

### Filling the Void

Given the troubling experiences direct-care practitioners had with the therapeutic void at Mountain View, it is understandable that many of my colleagues attempted to fill it even though

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<sup>51</sup> Citing LaFromboise (1993), Garrett et al., (2014) report that “[c]ultural ignorance on the part of the service provider is the number one reason for high treatment dropout rates and underutilization of help-seeking behaviors among Native people” (p. 481).

they were not officially trained to do so. In fact, one of the consequences of the therapeutic void at Mountain View was that the kids would often reveal their trauma to direct-care workers they trusted and put these direct-care workers in the position of being de facto therapists. Indeed, these kids often looked to direct-care practitioners to fill the therapeutic void.

As reported by Dylan, “I believe we do more therapy in the direct-care setting than the therapist does as a whole.” In addition, he believed “some staff do a very good job of addressing these issues.” However, when I asked Dylan if he was trained to deal with trauma, he replied “no. I believe our training says—you know—tell the therapist.” For example, Dylan reported “I had one boy who confided in me that as a child he was burned by his uncle with lighters. I had a very—very good—rapport with this kid and I brought it up directly between him and [Daisy]. He told me he was going to tell her and when they began therapy I walked into the room and I said—you know—‘did you tell her about the thing.’ And he was like ‘no, not yet’ and then he brought it up and she was completely shocked and had no inkling that any type of abuse like that had ever happened.”

When I asked Jimmy if it was part of his job to be someone the kids confide in, he replied “I think it’s part of your job—or my job—to be able to talk to them, be able to answer those questions, be able to have some type of response to help them out with the particular issue to the best of your ability—or the best of my ability—and sometimes you find yourself like playing the counselor role, you know.” When I asked him what he meant, he stated “kinda like a therapist—you know—you’re kinda there and you kinda explain to them certain situations about how to act and how to be.” For example, Jimmy told me “I was talking to one resident and this particular person was talking about how he wanted to cut himself with a piece of metal and I’m like ‘well, why would you do that?’ and he’s like ‘well because I wanted to put my brother’s name on my

arm or my sister's name on my back' and I'm just thinking to myself well 'that doesn't occur [to you] like something odd, weird, or maybe wrong to you' and he thought it was cool." Although Jimmy wanted to explain to him 'hey, you know that you're hurting yourself . . . and you should look at this as something that's not a very good behavior,' he added that trying to "help them understand that and not being able to is the difficult part." Although Jimmy didn't mind playing the counselor role, the difficulty he encountered demonstrates that he was out of his depth.

According to Lance, "I don't know how well [Daisy] counsels them, but I think at some level, all the staff do the same thing. We have to walk the kid through the problem, talk to them about their feelings. It may not go as deep as maybe the therapist does, but we definitely go into the issues with the kids." When I asked him if he thought direct-care provided therapy, he replied "on a daily basis we do. Half the tools that we use are therapy tools. Therapeutic holds, life space interviews: those are therapeutic methods of working through the problems and building stronger relationships. So yeah, we definitely do. I think we do the majority of the work: the staff. The therapist gets to come in once—twice—a week for an hour at a time. I mean how much can you really accomplish. We're there twenty-four-seven."

While Jimmy and Lance appeared to be comfortable playing the *counselor role*, others felt uncomfortable playing therapist. For example, Charlie reported it was "too much" for him and that it required a "higher level of care." Similarly, David revealed he didn't "want to do more harm than good" because he wasn't a "trained therapist." When I asked David what his responsibility was when kids confided in him about their trauma, he reported "umm, (long pause) . . . I never really thought about it before (chuckling)." He then added, "I mean, if the kid brings it up—personally—I think you got to do something about it." In addition, he mentioned that in the past "I've told them to go talk to the therapist—I mean—that's the only licensed—

trained person—who could really deal with the situation.” However, David added that “dealing with the therapist we have right now, I probably could do a better job than she.”

At Mountain View, it was commonly recognized that Luna was the one who primarily filled the therapeutic void. According to Krystal, “the boys didn’t really like the therapist, so a lot of them wouldn’t open up to her, but would open up to [Luna] instead.” She then added, “I feel as though the therapist on site—majority of the time—would be [Luna], but again, she’s not trained.” Similarly, Beth reported that “[b]efore [Luna] left, I think she was mainly the person that the kids talked to about their problems.” In her experience “I would say the only weakness we have is the therapist doesn’t really talk to the kids at all.” However, in her experience, “I think the staff are doing a really good job talking to the kids . . . I think the staff, themselves, they do a good job, right now.” When I asked her if she thought the kids were getting enough therapy, she replied “I think that they get enough counseling from us.” Thus, while some staff were not comfortable playing therapist, Krystal and Beth believed that practitioners like Luna not only played therapist, they were also more successful than the actual therapist.

In addition to playing—and to some degree succeeding at—the counselor role, some direct-care staff filled the therapeutic void by involving parents when they had the opportunity. Beth, for instance, revealed that she talked to some of the Native American parents about their kids and would provide them with information about what seemed to work with them in practice. In return, the parents would reveal to Beth what worked for the kids at home. Similarly, Don reported that he recently had the opportunity to meet the parents of one of the Native American



kids at Mountain View. He told me “I sat down with them last weekend. They didn’t know how he was behaving. They got to hear it, you know.”<sup>52</sup>

Although Beth and Don attempted to fill the therapeutic void by involving parents when they had the opportunity, they ultimately believed that family involvement at Mountain View was insufficient. Beth believed the company should be teaching the parents how to work with their kids. According to Don, “[w]e need parents in front of us (tapping his finger on the table) ‘this is how your child is behaving’ . . . I think that [with] any behavioral problems, the parents should be involved. The essential figure [in] the child’s life should be involved.” Similarly, Krystal believed “[t]he family needs to be in tune with what’s going on, so that when they leave from the group-home . . . the family can have an understanding of what the boy has been through as well as the boy can have that comfort of knowing that their parents—or parent—know what’s going on.” Although these sentiments are in keeping with the intent of ICWA, the lack of family involvement at Mountain View not only added to the therapeutic void these kids faced, it also exposed how the state was complicit in prioritizing behavioral correction over culturally appropriate care.

### Perpetuating the Void

Despite the Federal requirement to provide Native American youth in child welfare systems with culturally appropriate interventions, the state permitted ABC to perpetuate the legacy of culturally incompetent services that fail to “meet the Indian child’s needs” (ICWA: § 1915 (b) (iv)). When the state sanctioned the use of generic behavioral interventions, it enabled

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<sup>52</sup> While Goffman (1961) argued that “[l]ow-placed members tend to have less commitment” to the organization than “higher-placed members” (p. 201), this study reveals that not only were naturals highly committed to the mission of the organization, but as a group, my Native American colleagues tended to be particularly likely to engage in “contained secondary adjustments” that enabled them to achieve the goals of the organization through unauthorized means (Goffman, 1961, pp. 199-200).

all of its providers—regardless of profit motive—to prioritize behavioral correction over culturally appropriate care.

Once again, however, ABC can rely on a paper-trail of propriety to evade these criticisms. Here, the science behind generic behavioral interventions becomes part of the paper-trail that deems such interventions to be appropriate. Although Native Americans have been largely excluded from the studies that make up this science, its taken for granted assumptions suggest that it should apply to everyone, regardless of cultural differences. In addition, ABC can point out that it provided its direct-care workers with cultural diversity training and that it hired Native American practitioners.

Although my colleagues detailed a slew of troubling experiences regarding the provision of therapy at Mountain View, these experiences remained in the shadows as the state largely relied on the paper-trail produced by ABC to conduct its oversight. In this manner, the state enables counterfeit therapists like Daisy to evade detection as their paperwork and credentials are given the benefit of the doubt.<sup>53</sup>

For example, as part of the upper management team, Gary critiqued the insufficiency of therapy to his superiors. However, he reported that “my criticisms have gone unchecked” and have “been completely . . . ignored or [it’s been] decided I don’t know what I’m talking about...” When I asked Gary why that might be the case, he responded “because I don’t have a degree . . . in therapy... I’m not qualified to make a judgment.” Although Dylan also complained about the lack of therapy, he indicated that “it seems like there’s no recourse if I believe somebody that has more power in this company than I do . . . [isn’t] doing their job: even though it negatively

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<sup>53</sup> On 8/27/08, I lamented that during the course of collecting my interviews “I had become quite convinced that not only was the house therapist not doing her job, defrauding the pay sources and the families that believed their children were getting therapy, but she was also affecting some of the kids negatively on account of her negligence.”

impacts me.” Similarly, Luna—the group-home manager—indicated that she also complained about the lack of therapy “every day, ten times a day, in writing.” When I asked her how her complaints were responded to, she said “negatively.” Sadly, Daisy was able to sidestep these criticisms because of her credentialed expertise; that is, she benefited from a paper trail that deemed her to be the expert with the power to decide what is and what is not sufficient therapy.<sup>54</sup>

In addition, Luna revealed how easy it was for Daisy to evade criticism. For instance, when Luna would inform Daisy that “this boy really needs to see you . . . it then became [an] uphill battle . . . it would always be the same thing about, ‘well, I don’t see him until Tuesday; I don’t see him till Thursday.’ ‘Well, they need you now’ . . . I was always told that they need to have to work through a lot of their problems on their own. I was like, ‘well that’s not what a therapeutic group home is.’” Although Luna directly challenged Daisy’s commitment, Daisy benefited from the assumption she had a superior understanding of the therapeutic needs of the kids.

However, when Daisy did meet with the boys, Luna reported “every time that a boy was not opening up to the therapist, it was always—automatically—‘well, they refused therapy.’” Frustrated, Luna vented that to “have the audacity to blame the kids for not wanting to participate; that’s what killed me the most.” As revealed by Luna, this blame switching was not only audacious, it was also brazenly deceptive. Indeed, when the words “refused therapy” were committed to paper they were able to transform a traumatized child into a resistant child and an

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<sup>54</sup> As noted by Foucault (1977), the expertise attributed to psychologists has served to justify a hold “on individuals; not only on what they do, but also on what they are, will be, may be” (p. 18). Further, the degree to which the therapist’s assessments trumped the assessments of direct-care workers and the group-home manager demonstrates the degree to which the disciplinary gaze at Mountain View was hierarchical.

incompetent therapist into a competent one: even when that competence was directly challenged from below.

While Luna felt that a therapist should at least “go that extra inch to help that boy,” the generic behavioral design of Mountain View minimized contact with a master’s level therapist. Thus, the very design of the program—sanctioned by the state—was part of a paper-trail that not only allowed Daisy to refuse to meet kids outside of their appointments, but also enabled ABC to downplay the importance of a therapist altogether. As reported by Alex, “[t]he therapist provides the individual, group, and family therapy; which I don’t think is as important, because if you have kids short term, by the time you build a rapport, they’re ready to go. Not that I don’t...(pause). Obviously, it’s important, but again, I just feel that the milieu is the most important component of group-home services.” By invoking the importance of the milieu as the context for behavioral change, Alex evades the critique that therapy is insufficient. In particular, he does this by minimizing the therapeutic contribution of the therapist and elevating the therapeutic importance of direct-care staff.

In regards to family therapy, however, Alex acknowledged that it does not happen “as often as it should. I don’t think that’s completely our fault, to be honest.” He explained:

You know, we’re dealing with a funding source, we’re dealing with families. A lot of times the families don’t want to do it because they were part of the issue. It should occur more, but again, I think it’s not because we’re not trying on our end. I think we’ve had a couple therapists that probably avoid family therapy. It’s tougher. You know, it’s just hard. You know, you got the kid, you got the parents... (pause). I would imagine.

When I asked Alex if this was just a hunch, he replied “no, no, I know... I know. I think that, obviously therapists aren’t going to acknowledge that, but just kind of hearing all sides of the story, I’m pretty confident that they just don’t like the interaction.”

In the course of acknowledging that some therapists might be avoiding family therapy, it becomes clear that no one is making sure that it happens or that their documentation is in fact accurate. In regards to group therapy, I wrote in my research journal:

[Daisy] has been consistently aloof and her group therapy sessions come across as irrelevant to anything these boys are going through. In my eight years of working in this field and of having known many therapists and seen the interactions between therapist and client, she has by far the worst rapport of any I have witnessed. She remains, however, because . . . [n]o one seems to be overseeing or scrutinizing the actual quality of her work: that is, in terms of client well-being as opposed to billable hours; which I am sure she is excellent at (Journal Notes).

In fact, a number of my colleagues believed Daisy was making up her paperwork. While Luna questioned the authenticity of her claims that the kids “refused therapy,” Beth was clear that she believed Daisy’s paperwork was “made up.” According to Dylan, “on her side it’s more of the case of you need to make it look like you’re doing your job.” He would lament:

It just seems like, as long as—in this field, as a whole—as long as you can do the paperwork saying you do your job, it’s official that you do—do your job—and that’s all that matters: not what a kid says, not what another staff says, it’s what your paperwork says.<sup>55</sup>

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<sup>55</sup> In addition, Dylan complained that Daisy “hasn’t exactly been held accountable. There is physical proof through our paperwork, but on her side it’s more of the case of you need to make

Indeed, ABC, the state, and the “field, as a whole,” appear to be complicit in enabling therapists like Daisy to provide poor quality therapy and then cover it up in their paperwork. Sadly, after my interview with Alex—which was shortly after Daisy left the company on her own—I wrote in my research journal how “he acknowledged . . . that the therapist had essentially covered her tracks” (Journal Notes). While I would like to believe that Daisy is an isolated example of a counterfeit therapist, it is clear that she was enabled. Although the therapeutic void at Mountain View motivated internal criticisms, the state was complicit in allowing it to continue as it enabled a paper-trail of propriety to cover it up. Not only does this permit individuals like Daisy to evade criticism because of a paper-trail that assumes they are competent, it also allows them to evade criticism through the paperwork they produce.

### Conclusion

Despite the intent of the ICWA to keep Native American families intact and avoid restrictive and culturally inappropriate placements, my colleagues revealed that the Native American youth at Mountain View were often placed 100 miles away from their families and cared for by mostly non-Native practitioners—such as myself—who were ignorant of Native American cultural diversity. My colleagues and I were also unaware of how our culturally incompetent interventions put these kids, their families, and their communities at risk of continued suffering at the hands of the state. Not only were many of my colleagues unaware of how the simplest behaviors could be misunderstood because of their ignorance of Native American cultures, they were also unaware of the culture shock the kids were dealing with. Although the program’s intent was therapeutic, it imposed an individualized conception of pathology on these children that ignored the collective sources of their anguish. In addition, it

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it look like you’re doing your job, at least. I mean, if there was any muscle in holding her responsible then she would have been doing her job.”

ignored the individual-level trauma these kids were dealing with as direct-care workers were trained to deal exclusively with surface behaviors. Ultimately, this produced a therapeutic void that was both discernable and disturbing to the direct-care staff. Tragically, this void was amplified even further by the overall cultural incompetence of the program. The group-home therapist was unable to establish a therapeutic relationship with these kids and the state failed to ensure that she could. Although the kids at Mountain View looked to their direct-care workers to fill this void, many were in over their heads.

However, in the process of applying their behavioral interventions, my colleagues would become keenly aware that the youth we served were dealing with trauma that was linked to environmental distress. Although this trauma would largely remain unexamined and untreated, it tended to reveal the limits of generic behavioral treatment. While the tension produced by what was examined and what was left unexamined would lead to valuable insights regarding the need to intervene at the family and environmental level, it never led my colleagues to acknowledge that the behavioral program did not work. In the face of inevitable failure, my colleagues maintained an inflated sense of efficacy that behavioral interventions can fix the child. The degree of program denial at Mountain View is both perplexing and troubling; especially when considering that inevitable failure was a lived-experience. Nevertheless, the recognition that the sources of behavioral problems resided in the traumatic experiences these kids endured not only unsettled diagnostic understandings of these youth, it also propelled my colleagues to imagine how things might be different if programs like Mountain View worked with their families instead of tearing them further apart. Unfortunately—however—the tragedy of Mountain View is that it is a modern-day example of how state intervention produces further suffering in the communities it is intended to serve.

## Systemic Endangerment

Timber was a member of the Badger Tribe, six-foot-four, three hundred plus pounds, and larger than any fourteen year old ought to be.<sup>56</sup> He was also about to explode. We all knew it. It was just a matter of time. His mother had become seriously ill and—like many of our kids—he wanted to be home with his family—by his mother’s side—but instead he was with us: well over 100 miles away.

When Timber finally did explode, it took four adults to hold him down. Although most of us had been trained to use Therapeutic Crisis Intervention (TCI), we all knew that if Timber ever posed a danger to himself or others, the *therapeutic holds* of TCI (see Nunno, et al., 2003; The Family Life Development Center, 2003) would be useless. I wasn’t there that day, but I heard the stories. Luna held onto one arm. Dylan held onto the other. David held onto one of Timber’s legs, while JT—one of the newest direct-care workers—held onto his other leg. In the process of physically restraining him—which was described as “chaos”—Luna fractured her arm and JT had a chunk of his shoulder-length hair yanked from his head. Cuts, scrapes and bruises were sustained by all and blood—I was told—was everywhere. In the aftermath, I saw the damage done to the walls and I witnessed trauma in the eyes of my friends and coworkers (see Bath, 1994).

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<sup>56</sup> Timber is a fictitious name.



This four-on-one take down was not TCI, but—then again—a TCI-hold would have been impossible. Nevertheless, my co-workers were able to prevent Timber from getting into the sharps-closet. Had he broke open the door—which he was physically capable of—and got his hands on any one of our randomly assorted kitchen knives, who knows what might have happened?

To say that my colleagues and Timber were at risk of serious harm is to put it lightly. What this Chapter will reveal is how my colleagues and the adolescents they worked with were routinely placed in danger. Indeed, this chapter will show how Mountain View, the company that owns it, and the state were implicated in systemic endangerment.

#### Therapeutic Crisis Intervention

At Cornell University, researchers understood that if direct-care workers were not trained to deal with crisis situations, they might meet aggression with aggression: violence with violence. Thus, TCI was developed in 1980 to provide practitioners with skills to de-escalate crisis situations and to safely restrain youth when they pose a danger to themselves or others (Nunno, et al., 2003). As a crisis intervention strategy, TCI is “based on the premise that the successful resolution of a child’s crisis is dependent on the adult’s ability to respond in the most caring, therapeutic and developmentally appropriate manner possible” (p. 296). Within the TCI framework, a child’s aggression is viewed as an “expression of need” and direct-care workers are trained to respond in a way that “reduces the potential for their own counter-aggression.” Direct-care staff are trained to “monitor their own level of arousal to aggression, to use active listening . . . and other behavior management techniques.” When children cannot be de-escalated and they become a danger to themselves or others, “safe and therapeutic physical management techniques are taught” which “minimize the risk of injury” (p. 296).

As part of an initiative to prevent “institutional abuse,” TCI was funded in 1982 by a Federal grant from the National Center on Child Abuse and Neglect (Nunno, et al., 2003, p. 297). An initial evaluation of the program found that reports of child abuse decreased significantly “in those facilities that implemented TCI.” Since then, TCI trainers have been registered “throughout North America, the United Kingdom, Russia, Australia and Ireland” (p. 297). Because TCI promotes “the dignity and wellbeing of children in state care,” it is regarded by its developers as in keeping with the United Nations’ Convention of the Rights of the Child (The Family Life Development Center, 2003, p. S3). Although TCI is not considered to be *evidence-based* by the predominant standards of social science, it is supported by research (Nunno, et al., 2003). In fact, a 2003 study by Nunno, Holden and Leidy found that “TCI was successful in substantially reducing critical incidents, significantly reducing documented physical restraint. . . and increasing staff knowledge, confidence and consistency in crisis intervention” (p. 295).

Yet, the use of physical restraints with troubled youth is quite controversial (Day, 2002; Mullen, 2000; Nunno et al., 2006; Smith and Bowman, 2009). Proponents argue that these interventions “may be necessary to protect an aggressive child and others from harm” (Bath, 1994, p. 41; see Day, 2002; Mullen, 2000; Nunno et al., 2003; Nunno et al., 2006).<sup>57</sup> In addition, it has been suggested that physical restraints can actually be *therapeutic* as they can provide youth with “limit-setting needs,” prevent “reinforcing violent and destructive behavior,” and can provide “destructively aggressive” youth with “containment” (Bath, 1994, p. 43; see Day, 2002). However, the use of restraints can also be counter-therapeutic if they involve “any hint of verbal or physical counteraggression,” if they are used instead of “less intrusive approaches,” or if they occur under less than optimal circumstances; such as when staff are poorly trained, poorly

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<sup>57</sup> Others have argued that restraints should only be used when the potential for physical danger is “imminent” and only as a “last resort” (Curie, 2005, pp. 1139-1140).

supervised or when the staff-to-client ratios are less than ideal (Bath, 1994, pp. 46-48; see Mullen, 2000). While restraints may be counter-therapeutic when done improperly, some “critics of restraints” argue that even when done properly “children with histories of abuse and neglect, perceive these interventions to be aggressive and punitive” (Nunno, et al, 2006, p. 1334; see Crosland, et al., 2008; LeBel, et al., 2004). In fact, interviews with children indicate that those who have histories of trauma can be retraumatized during a restraint (Smith and Bowman, 2009; see Hodgdon, et al., 2013). Indeed, some argue that physical restraints are “not therapeutic” at all and may send the message that “the use of force is an appropriate way to deal with conflict” (Murray and Sefchik, 1992, p. 524). Additionally, it has been argued that restraints “are a product of treatment failure” and should never be thought of as *treatment* (Curie, 2005, p. 1139). Moreover, there are “frequently raised concerns about the risk of severe physical and psychological injury and death when restraints are used on children” (Nunno, et al., 2006, p. 1334; see Delaney, 2006; LeBel, et al., 2010). Tragically, Nunno, Holden and Tollar (2006) found reports of “[f]orty-five child or adolescent fatalities between 1993 and 2003 . . . that involved physical or mechanical restraints” (p. 1335).<sup>58</sup> All forty-five of these children had “behavioral, emotional, psychiatric, or developmental disorders” (p. 1337). Eighteen percent of them were in group-homes or foster-homes and thirty-eight of the forty-five fatalities involved the use of physical restraints.<sup>59</sup> In these reported incidents, none of the behaviors of the kids met “the standard of danger to self or others” while many of them involved “dangerous techniques” by the staff (pp. 1338-1339). Nunno, Holden and Tollar (2006) warn that physical restraints “are high-risk safety interventions with fatal consequences if applied incorrectly” (p. 1340).

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<sup>58</sup> Others have estimated that the number of “restraint-and seclusion-related deaths per year in caregiving agencies” could be as high as one hundred and fifty (see Mullen, 2000, p. 92).

<sup>59</sup> Further, “[c]hild psychiatric and residential treatment centers accounted for 60% of the fatalities” (Nunno, et al., 2006, p. 1339).

Given the controversy surrounding physical restraints with children, their potential for tragedy and the recognition that their usage has become ‘usual practice’ in many out-of-home treatment settings, states such as Massachusetts are now working towards “reducing and eventually eliminating” the use of physical restraints with children and adolescents (LeBel, et al., 2004, p. 40; see Crosland, et al., 2008; LeBel, et al., 2010). In Massachusetts, a statewide initiative to incorporate “strength-based models of care” that emphasized replacing restraints with “nurturing interventions” resulted in significant reductions in the use of restraints as well as fewer injuries to staff and children (LeBel, et al., 2004, pp. 40-43). In Florida, the implementation of a “proactive behavioral approach” at two facilities also resulted in significant reductions in the use of restraints and fewer reported injuries (Crosland, et al., 2008, p. 406). In addition, the six core strategies endorsed by the National Association of State Mental Health Program Directors—an evidence-based approach for reducing restraints—have successfully reduced restraints by over ninety percent in a number of programs across the country (LeBel, et al., 2010; see Valenkamp, et al., 2014). While a variety approaches for significantly reducing the use of restraints are now emerging, this area of research is still “underdeveloped” (Valenkamp, et al., 2014, p. 173; see Delaney, 2006; LeBel, et al., 2012).

Meanwhile, the use of physical restraints “remains largely unregulated” and “commonplace in programs serving troubled children and youth” (Smith and Bowman, 2009, p. 59; see LeBel, et al., 2010). For instance, in a study of practitioners’ experiences using physical restraints at a juvenile detention facility, “safety” was commonly cited as the general justification for restraints while “noncompliance” and “instructional control” were frequently cited as the specific reasons they were used in practice (Smith and Bowman, 2009, p. 67). That is, “most of the children they restrained were restrained for not following the rules” (p. 67). Although these

juvenile justice practitioners were trained in de-escalation techniques, “[i]n most cases, verbal intervention resulted in an escalation rather than de-escalating the child’s behavior” (p. 72). Further, interviews with children who were restrained at this facility indicated that the restraints could have been avoided if staff just talked to them about their feelings and listened to them (Smith and Bowman, 2009). Thus, despite the nationwide call by organizations such as the Substance Abuse and Mental Health Services Administration to “eliminate” the use of restraints in treatment facilities (Curie, 2005, p. 1139), it is clear that far too many children continue to be placed at risk (see LeBel, et al., 2010; Nunno et al., 2006).

Due to the paucity of research exploring how physical restraints are used in practice, it has been argued that “understanding staff perceptions” of what leads to the use of restraints is needed (Delaney, 2006, p. 25; see Valenkamp, et al., 2014). In addition, it has been argued that qualitative research “investigating organizational aspects” of restraint reduction approaches is also needed to better understand their “practical implications” (Valenkamp, et al., 2014, p. 173). In this Chapter, I will address these gaps in the literature by exploring the experiences of front-line direct-care workers who have been tasked with implementing TCI—a restraint reduction strategy—in an anger-management group-home setting. In particular, this Chapter will focus on how these practitioners experience the organizational structuring of their TCI practices as well as how they experience the use of TCI in crisis situations.

### Occupational Abandonment

In theory, TCI should govern the crisis intervention practices of direct-care workers (Nunno, et al., 2003; The Family Life Development Center, 2003). By providing direct-care workers with a range of “tools” for de-escalating children who go into crisis, TCI training is designed to build the “confidence” needed for practitioners “to be in control of the situation”

(The Family Life Development Center, 2003, p. S4). At Mountain View, however, practitioners perceived the structuring of their TCI interventions to be unrealistic, insufficient, and often non-existent. When the TCI training they were provided with failed to govern the reality of the situations they encountered, my colleagues experienced what I call *occupational abandonment*. That is, they were abandoned to deal with unacknowledged realities of the job.

For example, when I asked Krystal about the TCI training she received, her first reaction was to chuckle. She then told me “um—yeah—well they said that I was trained.” When I asked her what she meant by that, she replied: “[t]hey put us through TCI training, which was one day . . . just one day, which is definitely not enough.” In addition, she lamented “um, you’re told that you are meant to deescalate, but you’re not really trained to deescalate a situation.” Further, she indicated that “TCI training was good when you were able to put down someone who wasn’t really fighting back, but when you have some boy flailing himself all over the floor, yelling, screaming, swearing, spitting, everything else, you have no control and it’s definitely harder. It takes a lot of strength out...” In addition, Krystal revealed that her experience on the job was particularly difficult “especially since I worked the weekend shifts—from two to ten—which meant eight hours of being in a house with me and *maybe* two other staff—if not one—most of the time one, and having to do a restraint on a boy when there’s two staff members, between I think the lowest number of boys I worked with was five, and the highest was eight. So, having to control one boy as well as control the rest of the house was definitely difficult.” Thus, Krystal often found herself in situations where the ratio of residents to staff was higher than expected and difficult to manage. Indeed, the advertised ratio at ABC was three-to-one as opposed to the four-to-one ratio she encountered in practice. Further, Krystal found that it was “difficult” to perform a proper therapeutic hold on a resident—which often required two direct-care workers—while

also maintaining “control” of the “rest of the house” when only two people were working. In fact, it was nearly impossible. According to Dylan:

I would say the training and the actual intervention methods we are provided with aren't enough as it is, even if you're trained on all of them. It's like putting somebody in a box and saying these are your only tools to deal with this person.

When I asked Dylan how he felt about doing restraints, he stated “[i]t's kind of like here's a basic guideline and you fill in the rest. So, I have a basic idea of the intervention and then the rest is kind of up to me.” In regards to the training itself, Dylan told me, “[y]ou get tired, and it's repeat after me, highlight. It's not interactive. It's not visual or auditory. It's just... (pause). It's kind of flat—in the first place—and although the intervention methods were covered, they were covered briefly on paper and I think once on like an eighties video.” In his experience, “the depth and the substance of the training wasn't there because a TV and writing on paper will never convey the actual event of having a kid with behavioral issues that wants to kill himself freak out: which is just the nature of the event.” When I asked Dylan if he thought staff were well trained to do therapeutic holds, he replied “I would say not at all . . . especially in my case and especially, as far as I'm concerned, with the people I trained with. I trained... (pause). I practiced therapeutic holds with like a ninety pound, five-foot-two girl who was calm and collected and followed my directions while we were placing her into a therapeutic hold . . . and in the house, we've had situations where a resident is running out into our street which is full of rocks and threatening to hurt himself and running away.” In addition, Dylan recalled that during his training “we had a particularly large lady who had to be treated very gently when we practiced the program and it didn't make sense that if you have to be calm during our training to

do these holds, how would [you] be able to perform one in real life? We had to be gentle on her and no kid is going to be gentle on you.” Further, Dylan revealed:

It was kind of like they told us—you know—that we’d have a certain amount of staff . . . you would have a staff ratio of this amount to this many kids, and you’d have other trained staff; and in reality, in the house—a lot of times—we were under ratio, under staffed.

Rather than feeling confident after they received their TCI training, Krystal and Dylan reported that the training they received failed to provide them with the tools needed to intervene with kids in crisis. Although Krystal understood that the skills she was provided with were “meant” to deescalate a child, she didn’t feel adequately trained “to deescalate a situation.” Similarly, Dylan believed that the “tools” he was provided with were insufficient. Although both Krystal and Dylan understood that their TCI training was intended to govern their crisis intervention practices, they revealed that—in practice—they were abandoned with inadequate training.

Echoing these experiences of occupational abandonment, Don stated “[w]e’re trained to put people in holds, but we’re not trained to [use them] as a last resort. We don’t have that.” In other words, Don was abandoned to figure out how to use less intrusive interventions before resorting to a physical restraint. When I asked Charlie if he believed the training he received was enough, he stated “no, definitely not.” According to Jimmy “it’s almost like you’re put in this position and it’s like someone throws a book at you and says ‘here, go do your job’ and you’re like ‘uhhh?’—you know—(laughing). It’s almost like you’re being set up for failure.”

In addition to being abandoned with insufficient tools, Krystal and Dylan also revealed that their TCI training was unrealistic. According to Dylan, covering crisis intervention methods



on paper and in a dated video failed to convey how these situations are encountered on the job. In practice, Dylan and Krystal experienced residents who were “flailing,” “spitting,” “threatening to hurt themselves,” and “running away.” Yet, Krystal indicated that her training involved restraining someone who “wasn’t really fighting back.” Similarly, Dylan stated that his training involved restraining someone who was “calm and collected.”

Sharing these experiences, David reported “the training doesn’t really reflect how the restraint usually goes down.” When I asked David what he meant by that, he stated “well, sometimes I’ve had to restrain kids by myself. Other times we’ve had kids that were so large that we had about four people restraining them. Other times, the kid just put up too much of a fight and you just had to grab a hold and try to get him into the best—the safest—position with the staff at that point.”

During the course of their interviews, my colleagues also reported they were abandoned to deal with a degree of danger they weren’t prepared for. According to Lance, “I was expecting—definitely—having to deal with some emotionally disturbed problems with the kids. A couple of weeks ago, I definitely didn’t expect to have my safety be put in jeopardy that far. One of the residents did have a weapon on him and it happened twice and when we were taking him down, we had to confiscate a weapon off of him [and] that really scared me because I didn’t want that weapon ending up in my back.” In his experience, this resident “was very volatile” and “a very intensive case.” During this incident, Lance reported that “we gave him a timeout and some time to sit down in his room because he was not compliant and was definitely starting to pose a threat to everyone else. When we took him down... (pause), once we sat down, he ran out of his room real quick and he grabbed something off of the heater vents. So, he actually knew the house really well and took off like the heating vent blade and hid it on him and I saw him do that.”

Lance explained further that the resident had “unsnapped” the heating vent blade “on each side. It was sharp on each side. So, he had it in his pants and when he ran into his room we went to go search for it. So, we ended up having to take him down because he was posturing and being very upset. We had him down for a while. We actually found the item on him. So, that’s kind of how that incident went down.”

When I asked Lance if the resident was threatening to use the heater vent blade as a weapon, he replied “[h]e was very angry and very volatile, so it could have very well ended up in one of the staff’s back, and the staff who was restraining him, he had very big beef with that staff; [he] very much disliked the staff. I wouldn’t put it past [him] that he would use it as a weapon...(pause). I mean, why else would you take that off of there? He knew what he was doing with it and we found—many other times—items that can be used as weapons in his room; so, I mean...” When I asked him if he had expected to deal with that kind of danger, he responded “[y]eah, I wasn’t expecting that. If that’s the danger that I’m going to be exposed to on a daily basis, I’d expect to have body armor, or Kevlar—you know—or at least some kind of protective device on me . . . so that was something that unnerved me about the job; which I didn’t expect.”<sup>60</sup>

Disturbingly, these conversations with my colleagues also revealed that direct-care workers were often involved in restraints without any training at all. When I asked Krystal if she

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<sup>60</sup> While the danger Lance spoke of was possible, there were a number of seasoned direct-care workers—including myself—who knew that it was highly unlikely the resident Lance was speaking of would resort to violence. As one of our most intensive clients, this resident not only suffered from the most extreme abuse of any of our residents, he was also known for stealing random items from around the house and crafting “weapons” to help him feel safe from attack. Although we did have to routinely search his room and confiscate these “weapons,” it was well known that he was highly unlikely to ever use them. As a new staff member, Lance may not have been aware of the reasons why this extremely traumatized adolescent would craft and hide “weapons.”

ever encountered staff who weren't trained, she replied "ah-hm . . . which is kind of funny. Because, my first day of work I was observing: which is a day that you just go in, watch everybody, how the program works and everything. By the end of my shift, a boy was in a restraint with one staff member who had been only half trained, another staff member who had not been trained at all and me, who was an observer." After I expressed my surprise ("wow"), Krystal explained that "the overnight staff member came in and had to take over the situation, but it was definitely an eye-opener to what the job was going to be from that point on: now when I look back." When I interviewed Charlie, he also revealed "yeah, I did one hold without the training." I asked him how that happened and he replied "ah, jeez... (chuckle) . . . um, I think we were kind of short staffed and then it got out of control when the kid was starting to cry and everything so I had to put him down and then hold him down for a little while." When I asked if he initiated the hold, he replied "yeah, because he was getting pretty upset and I thought he'd hurt himself." I then asked him if there were other trained staff around at the time and he responded "I'm not sure exactly. I think they were, or—actually, no they weren't." As he explained further, he indicated that Luna was "away for some reason . . . and we were just kind of stuck (laughing)."

Surprisingly, when I asked Lance if he had been trained yet, he replied "[n]o, I have not." Lance—who was "scheduled to train"—had been working shifts at Mountain View for "about a month and a half." During that time, Lance reported that he was involved in about "ten or twelve" physical restraints. Interestingly, Beth—who was primarily working the overnight shift at the time of this study—reported that she did only one therapeutic hold during the two and half years she worked at Mountain View. On that occasion, she did "a small child hold." When I asked her about her training, she indicated "I didn't get to do my TCI until a year later; after I came [on the

job].” In addition, she reported she had not been trained yet when she performed the “small child hold.” When I asked how she knew how to do the hold, she replied “I seen the staff do it (chuckling).” At Mountain View, some direct-care workers restrained kids without any training at all and some of them performed more restraints than others.

During my interview with Alex—the CEO—I asked him if he was ever aware of staff doing therapeutic holds before they were trained. He responded, “in the past I have.” He explained, “I think that if there is somebody who is not trained... (pause). Let me put it this way, if somebody is working that is not trained and a hold occurs, I would not hesitate to involve them in a hold by saying, ‘okay, hold their ankles like this’—you know—I do think that probably occurs. To what frequency, I don’t know. I don’t have a real good impression of that, but I know in training they’re instructed that you can’t hold a child until you receive TCI.”

When I asked Luna—the group-home manager—if she ever saw staff do holds without the training, she replied “yes, absolutely. And because of the fact—there again—because when you hire in desperation and you don’t have that training before you go in the house: yes. And even though the policy did state: well as long as you have a trained TCI person helping you... (pause). What is that? That has nothing to do with anything.” Interestingly, although Alex would not “hesitate” to involve untrained workers on therapeutic holds, Luna questioned the wisdom of this policy.

### Unexpected Agency

When Mountain View’s direct-care workers dealt with occupational abandonment, it was common for them to also experience *unexpected agency*: that is, having to rely completely on

their agency in unexpected situations.<sup>61</sup> Indeed, both Krystal and Charlie expressed surprise when they were put in the position of doing restraints without any training. For Krystal, the experience was an “eye opener.” Charlie reported that he felt “stuck” in a situation that “got out of control.” Overall, Dylan “imagined more formal training—um, just more leadership—from the people above me.” In his experience, “there’s a lot of judgment calls . . . that you . . . you don’t have a lot to go [on]. I remember specifically in training this is what I should do in this situation. Instead, it’s kind of on you and your own experience.” Although Dylan believed his TCI training provided him with a “basic guideline,” in practice he had to “fill in the rest.” Similarly, Charlie reported “I thought we’d have a little more control over the kids . . . I thought maybe there’d be more staff on at once. Sometimes there was just two of us and it got out of control a little bit . . . and I thought there’d be a little more structure in the program.”

As revealed by Dylan and Charlie, the authority they had been granted to intervene with kids in crisis was often ungoverned. The structure of the program often revealed itself to be nonexistent as things would “go out of control.” In addition, the training they were given often didn’t apply to the reality of the situations they encountered. In fact, it failed to prepare them for it. These experiences were unexpected precisely because Dylan and Charlie had expected these

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<sup>61</sup> Because my colleagues were not supplied with the appropriate means to achieve the goals of the institution, my colleagues were precluded from making “*primary adjustment*” to the organization (see Goffman, 1961, p. 189). That is, they were prevented from carrying out the appropriate means because they were never supplied with the appropriate means. While Goffman (1961) refers to the ‘programmed’ member of a total institution as an individual who “co-operatively contributes required activity to an organization . . . under required conditions” (pp. 188-189), my colleagues revealed that they had to rely on their agency in unexpected situations because they were either insufficiently programmed or completely un-programmed. Further, because the “organization’s assumptions as to what [the worker] should do” (p. 189) are unclear in situations of occupational abandonment, the concept of secondary adjustment is also inappropriate when the individual is not trying to get “around” those assumptions but merely trying to implement them with little to no guidance. Thus, unexpected agency could be understood as an unexpected adjustment to organizational/occupational abandonment.

situations to be governed by more training, leadership, and structure. Nevertheless, the direct-care workers at Mountain View had to figure out how to handle crisis situations without being adequately prepared and they had to do so under circumstances they did not expect. In these critical moments, they had to rely completely on their agency: an experience that was eye opening, troubling, and quite unexpected.

### Power Maintenance

At Mountain View, my colleagues understood that the group-home sanctioned the use of force when kids were on the brink of violence. That is, they knew they were in a position of power (see Foucault, 1977; Rhodes, 2004). Although it was generally understood that direct-care workers were expected to maintain the power of their position and to control the house, it was also expected that they balance this *power maintenance* with the dignity of the child.

Unfortunately, however, this balancing act often went awry. While restraints were often used to maintain the power of the direct-care position, they didn't always maintain safety or the dignity of the child. Even though it was generally understood that restraints should only be used when kids posed an immediate danger to self or others, they were occasionally used in a threatening, coercive, and abusive manner. Indeed, when some of our colleagues relied on their agency to maintain the power of their position, they endangered the kids, their coworkers, and themselves.

While some of our colleagues were less inclined to use restraints, most believed that power maintenance—in some form—was critical.<sup>62</sup>

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<sup>62</sup> Although my colleagues were in positions of power, the power they wielded was often resisted and contested by the kids at Mountain View (see Foucault, 1977). To maintain the power of their position, power had to be exercised. However, the power they exercised was not limited to disciplinary power. Indeed, the sanctioned use of restraints introduced an excessive, yet “humane,” application of power as it was intended to be governed by a “principle of moderation” (see Foucault, 1977, pp. 91-92) and a “calculated economy” (p. 101) that not only justified its use in very limited circumstances but also served to protect society while minimizing “excessive

When I interviewed my colleagues at Mountain View, it was clear that most of them viewed physical restraints as a necessary part of the job. For example, when I asked Beth if she thought restraints were necessary, she stated “sometimes” and explained that—in her experience—they were necessary “when they’re a danger to themselves or when they become dangers to other residents.” When I asked Don how he felt about doing restraints, he replied “nobody likes restraints. Nobody likes restraints.” When I asked him if he thought they were necessary, he replied “yeah, it’s necessary, but it should be as a last resort.” According to David, “it’s a necessary evil, but (long pause)... I mean, it’s just something you have to do.” When I asked Lance how he felt about doing restraints, he reported “restraints I feel are necessary.” In Gary’s experience as the group-home trainer, “for a safety situation, it is very, very, needed.” He explained that when “you got a kid running at you with a sharpened pencil, I don’t know that you have any other recourse—right then—to make sure the situation becomes safe again; but again when that’s taken away, the only element that’s going to change are the direct amount of arrests that are going to occur because of direct police involvement.”

At Mountain View, it was common to believe that if direct-care practitioners didn’t have this prescribed use of force at their disposal, kids might harm themselves, staff, or others. Further, as reported by Gary, direct-care practitioners might have to rely on the power of the state—in the form of the police—if they didn’t have the authority to use physical restraints. Therefore, it was common for Mountain View’s practitioners to believe that—one way or the other—the power of their position had to be maintained. In addition, many believed this included the use of force when de-escalation was not possible and harm appeared imminent.

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pains.” Although the ‘therapeutic’ holds of TCI were intended to influence the mind of the child and to prevent harm, their physically coercive nature demonstrates how corporal penalties are humanized and calculated as opposed to being completely eliminated from how we intervene in the name of treatment.

However, practitioners tended to vary in the degree to which they endorsed the use of restraints. While Beth, Don and David expressed a tempered reluctance in using restraints, Daisy—the therapist—reported “I’m all for them. I think that...(pause). Well, as you know, there’s supposedly this statewide, nationwide thing, to get rid of restraints and holds. I think that’s the worst possible thing they can do. I think that holds are necessary. I think this five minute BS of you have to release a child within five minutes . . . (pause) that’s crap, because he’s just starting and if he knows you’re going to release him in five minutes, it’s on; especially if he wants a piece of you. I think the more the better. I mean, personally, I wish that we could use soft restraints.” That is, Daisy endorsed the idea of using the type of mechanical restraints used in psychiatric hospitals.

According to Alex, “I think it’s a necessary part of what we do.” He explained further, “I don’t like prones. I wish we would get rid of prones, but it’s difficult because I know some of the bigger kids, I don’t know if they can be managed in less restrictive holds. I think there’s a national movement to eliminate holds. ABC, myself . . . we’ve always been...(pause) we’ve always been an advocate of holds and we’ve actually worked with the state quite a bit. I mean, I think the five minute rule is ridiculous. I think that it takes about five minutes just to get things to a point where they’re under control and then you have the de-escalation process.”

Although Daisy’s bravado may reflect the fact that her position doesn’t require her to perform restraints, it may also be based on her prior experience working in an adult psychiatric inpatient unit where mechanical restraints were commonplace in addition to physical restraints. While Alex is also exempt from having to perform restraints, he used to perform them when he was a direct-care practitioner. Thus, while the endorsement of restraints by upper-management may reflect their sheltered positions of power, other factors appear to play into the degree to



which restraints are endorsed as Alex knows—all too well—what it is like to be in the direct-care position. Indeed, although it was common for Mountain View’s practitioners to view restraints as an intervention that was needed to maintain safety, they tended to differ in their views of how necessary they were, how they could be avoided, how often they needed to be used and under what circumstances. That is, practitioners had different views of how the power of their position should be maintained and different experiences of how they were maintained. While most of my colleagues had experiences of power maintenance—that is, maintaining the power of their position—they maintained that power in different ways and some endangered the kids as a result. Indeed, a couple of my colleagues revealed they had to intervene when direct-care practitioners endangered the kids we worked with.

As my colleagues revealed their experiences performing restraints, witnessing others perform restraints and avoiding the use of restraints, it became clear that in practice, the manner in which practitioners maintained the power of their position and the child’s dignity varied because direct-care workers were—all too often—abandoned in unexpected situations with insufficient tools and without supervision. Indeed, they often had to rely completely on their agency to figure out how to balance these potentially conflicting priorities. In practice, some direct-care workers ceded power to the kids. Others reported that they relied on gendered power to negotiate crises. While a dangerous few relied on aggressive power, a small core engaged in attentive empowerment. These varying experiences of power maintenance emerged in the context of occupational abandonment. Moreover, the range of these experiences demonstrates

both the promise and peril of unexpected agency as these different means of maintaining power implicate the dignity of the child in different ways.<sup>63</sup>

### Ceding Power

In practice, David revealed there is a difference between “the staff that actually do holds compared to other staff who just let the kids go about their business and do what they want.” In his experience, “some staff let the kids get away with murder.” When I asked David what he meant by that, he replied “um, just let them walk all over them...(pause) let the kid do what the kid wants to do.” When I asked him why that happens, he stated:

[S]taff’s personality, just tired, um, maybe not getting the gist of the job. I mean, I think it just depends on each and every staff and there’s probably staff out there that really want to follow the program. They just can’t because they’re afraid of the kid or just physically not able to put the kid into a restraint or they’re just looking at the other staff and going you know ‘this guy isn’t going to help me out, why should I go put my neck on the line?’

Similarly, Lance reported “[s]ome staff don’t like to do them; just because they don’t like the confrontation, but you got to draw the line somewhere. You can’t let the kids walk all over you too.” When I asked Lance if he encountered situations where staff were not willing to do a hold, he reported “oh, absolutely. Yeah. Yeah.” I asked him how often this occurred and he replied “it’s only certain staff.” He explained further, “it depends on the size of the client too. If

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<sup>63</sup> Although the behavioral program was based on the use of disciplinary power combined with a calculated and humane application of force (Foucault, 1977), occupational abandonment created spaces for other forms of power maintenance to emerge. Indeed, when ABC failed to adequately train and supervise its practitioners in the use of deescalation techniques and the application of humane force, they were essentially left to exercise power in whatever way they saw fit. Because most of my colleagues understood that the power of their position had to be maintained, they developed different strategies for exercising power. While some of these strategies enabled practitioners to avoid using force altogether, others relied on excessive and inhumane applications of force.

the client is a larger client, they may be more apprehensive just because maybe they're not as confident in their therapeutic hold skills . . . I think some staff are apprehensive of the client's size." Moreover, Lance revealed "I haven't really seen a staff that's completely against it all the way. Like the staff that I've seen, they've been against it just for their own safety; because they thought they couldn't contain the person or they could possibly re-injure themselves."

According to Lance and David, they have witnessed direct-care practitioners let the residents do what they want and avoid doing restraints. Similarly, I wrote in my research journal:

I was talking to one of the new employees and she mentioned how one of the more senior staff (a person I consider to be weak staff) lets the guys do anything. She said he was too passive. She also indicated that she often had to tell him what to do (Journal Notes).

Instead of using the power of their position to help change these kids through behavioral interventions and crisis management, these practitioners ceded power to the kids so they could do whatever they wanted. In addition, it would appear that this ceding of power was based on their own self-interest and desire to avoid confrontation and harm.

Tragically, Krystal reported how an incident of ceding power to the kids resulted in her being caught between two arguing adolescents—without warning—and suffering a concussion as a result. As Krystal recalls, she was in the laundry room "at the back of the house" on a Sunday night when "something had escalated" "at the dinner table." Although the two other direct-care workers at the table knew what was going on and "could have deescalated the situation and sent both boys back to their rooms," they "let me deal with one of the boys when I called him to the laundry room to put his clothes away and then—before I knew it—the other boy was behind me and they were swearing, mouthing off to each other." Krystal was not aware of the situation at the dinner table "until I was in between two of the boys that were going at it." As she put, "I was

caught in the middle.” When she called for assistance, “it seemed like they took forever to come.” Ultimately, Krystal suffered a concussion by “getting punched in the back of the head . . . by one of the boys.” When Krystal talked about her experience, she placed blame on her co-workers for “not being, first, able to deescalate the situation, and second, not coming to my aid faster. But, it should have been avoided completely because one of the boys was bigger than us, so it should have been deescalated, because if it had reached a restraint, we wouldn’t be able to.”

According to Krystal, her co-workers should have never let an escalating kid out of their sight. In addition, Krystal believes they should have maintained the power of their position by de-escalating the situation and sending the boys to their rooms. Although Krystal suggested that her co-workers wouldn’t have been able to restrain one of the residents, she believed—nonetheless—that the situation could have been deescalated. In her experience, the power of their position—as well as their safety—could have been maintained without having to resort to a physical restraint.

Unfortunately, after Luna and the core of Mountain View’s naturals left the company, I noted in my research journal that ceding power was becoming the norm. On 9/9/08, I wrote:

Most of the staff seem less concerned with keeping a constant eye on the kids and with keeping them directed. On many occasions I have seen kids wandering out of the supervision of their staff as well as having access to privileges they are not supposed to; like watching TV or playing pool. In essence, most of the staff don’t follow the program (Journal Notes).

### Gendered Power

At Mountain View, some practitioners maintained the power of their position by relying on their gender. That is, some direct-care workers managed crisis situations by playing gendered

roles. According to Alex, “I think typically, when you have a large male as a staff you tend to have more holds with that individual and I think there’s a number of reasons.” He explained, “I think that men, in general, are . . . probably gonna command compliance a little stronger [while] our female staff will tend to process a little more.”

Although Alex admitted “this is my own perception,” he also indicated “there is some data to support that: where the male staff are quick to respond physically where the female staff are looking to process or deescalate verbally.” In his experience doing this work, Alex indicated “I think we tend to look to larger staff—typically men—to be the dad, to enforce, to be the disciplinarian.” Indeed, Alex recalls being placed in this situation when he was a direct-care worker. According to Alex, “people would have me initiate the hold.” Although he didn’t refer to his role as an enforcer or disciplinarian, his willingness to “respond physically” and play the role of a physical male was relied upon as his colleagues would avoid holds because “[t]hey were nervous.”

Similarly, Dylan referred to his physicality as a gendered resource he relied on during restraints. In the middle of a restraint, Dylan suggested that “if you don’t know the exact technique, you can rely on strength on occasion to overcome your lapse of technique, because the technique requires no brute force, as far as I can recall, that’s what it’s designed for. You’re not supposed to pin a kid down or push him and hurt him. You’re supposed to safely and effectively maneuver them to the ground and, as a girl, as the girls I trained with were definitely not as strong as the boys were, the two men in the training, . . . I’d imagine they’d have a tougher time during any restraints.” When I asked Dylan if he ever witnessed male direct-care workers relying on their strength to overcome lapses in technique, he replied “yeah, I’ve done that. I would say . . . (pause) if you asked me, I would fall under that category, but in a different way. I

have—at least—knowledge that, you know, it doesn't take much to break a bone; it doesn't take much to hurt somebody. So, I'd say, possibly, I'm more gentle, but I would include myself in saying, yeah, it happens all the time." When I asked Charlie if being male helped him work with the kids, he replied "I think it helped in some ways." He explained, "men are viewed with power, so it would probably give me a little more power. At the same time, the empathy part, I kind of probably lacked some of that because I'm not a female."

As shown in Chapter 1, some practitioners utilized a motherly role to establish natural connections with the kids at Mountain View. Although the motherly role was not invoked during restraints, it appears to have been an effective resource for preventing them. As reported by Luna, moms "will allow you to cry and will cry with you." Thus, it appears that Luna used this female gender role to defuse potential crisis situations by allowing the kids to process their emotions. Similarly, Beth suggested that restraints were antithetical to her motherly role. According to Beth, when members of the Bear Tribe are taught to treat kids "as though they're your own kids," that includes treating "all the behavior problems that they have" as something "you have to deal with." In her experience, "it was different coming here and ... oh, okay, this one has behavioral problems, that one goes over the edge and you're ... (chuckling) ... down in a hold, so it was different." Indeed, when Beth started working at Mountain View, she reported "nothing about the kids surprised me; it's just the way it was handled." When I asked her to explain, she stated things were "just different from the way I dealt with the kids on the reservation... Here, (chuckle) you get to wrestle the kids down (laughing)." In her prior work experience on the reservation, she revealed "you never got to that point. You never got to the point." When Beth learned that "[y]ou can actually put these kids in a hold ... I'm like 'okay?' ... you know. It was different and throughout this whole thing, I hardly ever put any kid in a hold." Thus, even though

Beth was given the authority to perform restraints, she used her motherly role to “deal with” the kids, to learn “what works” for them and to negotiate their “behavioral problems” without having to rely on physical restraints. In her experience, dealing with kids as though they are your own did not include wrestling them to the ground. Indeed, in her experience, the use of restraints was not only surprising, she also found it to be largely unnecessary. By relying on their motherly roles, Luna and Beth were able de-escalate the kids before they got to the point of needing a restraint.

Although Krystal was too young to take on a motherly role, she did rely on her gender to negotiate conflict at Mountain View. According to Krystal, “I used my advantage of being a female and the boys sometimes having a crush on me, to kind of be the one that has the control of the situation by asking them nicely to do something and they’d do it because I was asking them as opposed to another staff member.” That is, Krystal utilized her gender to achieve compliance. Indeed, she saw this resource as an “advantage.” Thus, while the male gender role of “disciplinarian” was used to “command compliance” through physical intimidation, the female gender role as an object of attention was used to achieve compliance through emotional manipulation. In addition, Krystal revealed this enabled her to maintain the power of her position when other direct-care workers could not. As reported by Krystal, those residents who had a crush on her would follow her directions while ignoring the directions of other staff. As an object of attention, Krystal was able to be in “control of the situation” by being nice. In other words, Krystal occasionally maintained the power of her position by utilizing a gendered role in place of behavioral interventions and the sanctioned use of force.

While Krystal was clearly acting beyond the bounds of sanctioned interventions, she took power maintenance very seriously as she revealed that “with any job where you’re working with

people that you either have to put in a restraint—whether it’s law enforcement or this type of group-home—you have to remember that, even if they’re nice to you and protect you a lot of the time—like some of the bigger guys did—they still have the tendency to—when they’re angry—they will fight you and fight you like you’re the same height as them, same weight as them, if not stronger.” In fact, Krystal revealed “I had a couple of incidents when they actually took out their aggression: once towards me, and once, I was in the situation, and they didn’t fight me like I was a female, they fought me like I was a man.” In this context—such as the one that resulted in her suffering a concussion—Krystal revealed that power maintenance was vital. Although Krystal viewed her gender as an “advantage,” it wasn’t the only way she maintained the power of her position at Mountain View.

#### Attentive Empowerment

As I talked to Krystal about her experience at Mountain View, it became clear that she was troubled that “restraints weren’t being enforced properly, because—a lot of the time—I felt as though they could have been avoided, or deescalated.” When I asked her if she was able to deescalate the kids she worked with, she replied “ah-hm. Um, it depends which ones.” De-escalation—in her experience—involved “different things for different people.” As she puts it, even though “you were trained to kind of deescalate a situation . . . every situation is different and every boy is different.” To provide an example, she revealed that “with one of the boys . . . to deescalate a situation, I would talk to him and if he’d just get mad, I’d crack a joke or like—you know—do our secret handshake that we had, and that would definitely work and he’d smile and I’d be like ‘come on, do you really want to do that?’ and he’s like ‘no’ and he’d be like ‘can I just go inside and get some water’ or something.” Ultimately, Krystal learned that these adolescents could be deescalated by “paying attention to what the boys needed and wanted.” She



explained, “if they wanted something, that doesn’t mean they always get it, but if they needed something, then you need to pay attention to that.” She described this attentiveness as “being more in tune.” When I asked her for examples of things the residents needed, she replied, “uhh, just needed someone to talk to for like five minutes; kind of take some time away. Maybe they had a bad day at school, or one of the other boys has been picking on them or something, but you don’t want to spend a lot of time because then it can turn into manipulation. So it’s very hard. It’s a very thin line.”

Although Krystal’s technique was resident-specific and situation-specific, she learned that de-escalation was possible and that *attentive empowerment* worked in practice. That is, the power of her position could be maintained by paying attention to what enables kids to deescalate and providing them with the opportunity to do so. Unlike the coercive and manipulative potential of gendered power, attentive empowerment maintains the dignity of the children by empowering troubled youth to utilize their own resources to deescalate.

Although Krystal indicated that attentive empowerment can be “very hard” to realize in practice, my colleagues revealed that when power maintenance is achieved without using force or emotional manipulation, it can lead to a sense of accomplishment. According to Don, “I’ve seen kids just blow up and hadn’t . . . put them in a restraint . . . Hey, I succeeded if I didn’t have to.” Similarly, Charlie revealed “I think if you were doing everything right, you could avoid them in the first place.” When I asked Charlie how he avoided restraints, he indicated that he “would confront some of their emotions or behaviors before they get really bad.” When I asked him how he did that, he reported “first, you send him to his room so he can cool down, and then you talk to him about it, and maybe process with [him].” Likewise, Beth reported “I think there’s

always a possibility that you can talk a kid out of their behavior . . . If you can do that, then you've accomplished something.”

In addition to using her motherly role to establish natural connections, Beth also utilized attentive empowerment to deescalate the kids. In her experience, when natural connections are established, the kids will confide in you and “tell you everything . . . even when they're in a crisis, before they start a crisis, or if they don't understand why they feel the way they feel.” To empower the kids, Beth would ask “[w]hen you're starting to feel angry, how do I deal with you, what do you want me to do, what do you want me to say to you?” and then they tell you. They would tell you and then when they start to feel angry, they seek you and then they tell you: ‘I'm starting to feel angry’ and then the direct-care would already know what to say to this kid because if you had that bond with that kid, you would already know what to do and since you're the one that has that bond, what you do is you tell [the] staff, ‘this worked for me, I don't know if it's gonna work for you guys...’”

By asking kids to indicate what works for them when they are in crisis, Beth was able to use her attentiveness to provide them with opportunities to deescalate. Although Beth found that attentive empowerment works in practice, in her experience, it was dependent on the establishment of natural connections. Kids would tell her what works for them and they would seek her out during a crisis because of the “bond” they had. Thus, what works for Beth may not work for another direct-care worker. In addition, what works for one kid may not work for another. The key was utilizing a natural connection to figure out “what works for this kid.” Indeed, attentive empowerment is attentive to what works for the individual as opposed to a generic one-size-fits-all approach. Although Beth, Krystal, and Charlie understood that these

kids could be empowered to deescalate, not everyone was attentive to what the kids were going through and not everyone could establish natural connections.

### Aggressive Power

When it came to the use of physical restraints at Mountain View, Beth believed “sometimes I think they overdo it.” Similarly, Don lamented “[w]e’re trained to put people in holds and I think that should be the last resort. It seems like that’s our first resort, or even [to] intimidate them even more to get into a hold.” According to Charlie, “TCI taught us that you try not to get in . . . the resident’s face. You try to avoid confrontation in a way. I think some new staff, without the training—or even with the training—they might let their emotions get out there and get in their face and confront them too hard.” When I asked Charlie if he ever witnessed this, he replied “yeah . . . well, I know one of the residents hated one of the staff and it was the same way around, so the staff was trying to have power over the child, [and the child] was trying to have power over the staff, so it was a power struggle the whole time and neither one of them backed down. [The staff] was telling [the child] to get in [his] room and he was refusing and so he was trying to get in his face more. It just kept getting worse, so then I had to intervene and tell the staff to sit down and then send the child to his room.” Charlie explained, “[y]ou don’t get in his face like that and you don’t demand like that. I mean, there’s subtle ways of trying to get them to do something.” In Charlie’s experience, this direct-care worker “caused a lot of problems (chuckling).” As reported by Charlie, “it was mainly with one child, but numerous children did not like him. So, it was as if he confronted issues too harshly.”

Similarly, Dylan revealed “a lot of times we had staff that made the situation worse and—you know—that’s never covered in training.” When I asked Dylan how staff made things worse, he replied “we had . . . (long pause) . . . I believe we had staff once that—I mean—it went

from simply yelling at a child to—in my mind (long pause)—uh, physically hurting a kid when it wasn't necessary.” Dylan indicated that his understanding of this was based on “reading reports and combining that with the fact that I worked with that gentleman a lot.” In addition, Dylan reported “we're required to never raise our voice with the kids. There are several staff that will raise their voice with the kids.” In his experience, “[i]t's tough because you hear a staff—you know—raise his voice to the kids or make fun of a child.” Moreover, Dylan revealed that during restraints, “I've had occasions where I've had to request that staff move pressure [during a restraint] or, on one occasion, leave . . . because they were making the situation worse.” When I asked Dylan if he ever witnessed staff being aggressive with the kids, he replied “definitely.” Disturbingly, when I asked Luna if she ever witnessed kids get hurt at Mountain View, she replied “ah-hm. I have seen kids get hurt to the point where they have had to go to the hospital and I have seen staff be so overly aggressive with some kids, when it was not necessary, where their intent—their true intent—was to hurt that kid.”

Alarmingly, despite ABC's mandate to care for troubled youth, some direct-care workers relied on aggression to maintain the power of their position at Mountain View. Instead of establishing natural connections with these kids, these practitioners created toxic relationships as they used confrontation, intimidation, and aggression to establish control. Their use of *aggressive power* manifested itself in the form of hostile posturing, verbal attacks, and physical assaults. Instead of de-escalating crises, these agitators escalated crisis situations. Although attentive direct-care workers intervened when their co-workers became aggressive, this aggressive form of power maintenance emerged all-too-often and endangered the kids as a result.

Losing Power

As my time at Mountain View came to a close, I began to witness a whole new power dynamic emerge. Instead of seeing staff maintain the power of their position in different ways, I began to see and hear about a variety of ways by which the kids had seized power for themselves. For example, on 9/11/08 I wrote in my research journal:

A couple days ago, I learned from one of my coworkers that one of the group-home residents had gone AWOL with a new resident. This information came to me as we were hanging out: off site and off the clock. At the time—somewhere around 11pm—the whereabouts of these two kids were unknown. Jokingly, but also half-serious, I told my friend/coworker that they were probably at the “fort”: a teepee like structure that the kids had built a couple years ago alongside a local trail. Sure enough, the next day I learned that the police found them there. Apparently, they had gone to a local corner store, broke in by throwing a rock through the glass door and stole beer, junk food and pornography (Journal Notes).

During most of my time at Mountain View, it was extremely rare for kids to leave the grounds. However, after Luna was terminated and the core of Mountain View’s naturals began to quit—one-by-one—AWOLs suddenly began to occur with greater frequency. Although one of the residents who committed this corner store heist was considered to be one of our most difficult to work with, I mentioned in my journal that I highly doubted he would have left if either Dylan or myself had been working that night. While I stated that “[i]t is hard to put into words why,” I went on to write “[w]hen healthy relationships are built, there are many unconscious boundaries that are maintained/respected. While I can’t speak for [Dylan], I think that this particular resident values the relationships he has with us” (Journal Notes). By way of contrast, I noted that “[o]n the night he went AWOL, one staff was new and the other was one he’s told me that he knows

he can manipulate.” In other words, this resident had found a way to “manipulate” some of our weak staff.

Unfortunately, when weak staff are manipulated, tricked or simply ignored, they lose the power of their position and—as reported by Gary—the state is then relied upon to regain that power as police are called into action when our runaway youth run amok.

In another incident—about one month later—I wrote:

During the overnight, two different residents went AWOL. It sounded as if the overnight staff was doing the required room checks, but the residents had ‘tag-teamed’ much of the night trying to get into each other’s rooms to communicate and distract her. Eventually, they both snuck out of their windows in between her fifteen minute checks. This overnight is also very new. A strong overnight person would have placed their chair in front of one of their rooms and watched them all night long. Chances are that neither one would have ventured out on their own (Journal Notes).

While trickery and tag-teaming allowed residents to dupe weak staff and then cause havoc in the community, weak staff were also manipulated into giving residents privileges they haven’t earned. On 9/12/08, I wrote about how a “resident [who] attempted to stab me with a pencil a few weeks ago . . . was advanced in level and given our upstairs room; one typically reserved for higher level kids that we can trust with access to an outside balcony.”<sup>64</sup> I went on to write:

When I reminded the staff who had recommended it and the interim manager they were both apologetic and had indicated that they had forgotten about the recent stabbing

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<sup>64</sup> Prior to charging at me with a pencil, this particular resident was threatening to cut himself with it. After multiple extended attempts talking him down and trying to get him to hand over the pencil, he lunged at me with an overhand stabbing motion.

attempt. Since his level advance, he has been increasingly manipulative of staff trying to tell them how to score his dailies so that he can advance another level and earn offsite passes with his family. Prior to the meeting, the new staff told me how this resident had gone outside yesterday—out of supervision—and refused to go back into program.

When the regional director was reporting increased negative behaviors by this resident, I recommended that he move back downstairs to his old room since [the upstairs room] is usually reserved for better behaved kids. She thought it was a good idea... (Journal Notes).

To the extent that staff were listening to kids about how to record their daily behaviors and how to advance their levels, they not only lost the power of their position, but had relinquished it to the residents. While I was glad to facilitate the removal of this resident from the upstairs room he had bamboozled, I couldn't believe that someone who was known to be a danger to himself was granted a room that not only had a balcony but was also outside of our view. This level of staff manipulation never occurred when we had a core of naturals.

Indeed, this type of manipulation and trickery on the part of the residents to seize power and re-direct it for their own benefit is what distinguishes losing power from ceding power. In the case of ceding power, the direct-care worker purposefully allows residents to get away with violating the rules of the group-home so they can maintain their position of authority while avoiding conflict. In the case of losing power, it is the residents who actively manipulate staff into giving up their authority.

In my last journal entry, which was the same day I decided to put in my two weeks notice, I wrote about how I was beginning to lose the power of my position because there were virtually no naturals left to make the connections that were necessary to direct these kids and keep them

out of trouble. The last words I wrote in my journal before leaving Mountain View were “[a]s an army of one, I am powerless.” Prior to that, I wrote:

When they listen to me now, it is reluctantly. When some of the kids see me now, it is as if they resent the fact that I am the only one that holds them accountable the way we used to. They listen to me, but it’s more like they are putting up with a once a week annoyance. I feel like I am the lone enforcer of what used to be. Today, I realized how futile my efforts have become... I don’t fault the kids. I fault how the change over was handled. When the new manager came on, she never talked to myself or any other core staff that had been around to find out how we ran the house . . . The very basics of keeping the boys in supervision and holding them accountable for violating the house rules have gone out the window... I found out yesterday that the core of new staff had no idea that kids were supposed to be patted down when they came home from school. During a restraint tonight, there were countless contraband items in the resident’s pockets and his room that could have been used as a weapon. Earlier in the day, kids were using broomsticks as “light sabers” and it was clear this had been a routine activity for them. It no longer feels like a group-home where staff run the house. Now, it feels like a kids’ fun house where staff are constantly on the defensive and outnumbered. (Journal Notes).

At this point in time, I was the last person standing of the old core and I could no longer stomach how the new manager was running things. In my journal, I wrote:

Every Friday that I’ve worked, she is never at the home past 2pm. I have never seen her coach new staff. To be honest, I don’t think she knows how . . . [T]he new staff seem untrained or poorly trained. When I work, I have to do my job in addition to doing the job of the other weak staff just to prevent multiple crises from occurring. When I try to



enforce the rules and maintain order, I am, more often than not, working alone. There are new staff that have the potential of being strong, but there are no pre-existing strong staff to guide them and teach them. Although a few have looked to me for guidance, my once a week coaching doesn't seem to be enough . . . What I worked so hard to teach and instill has been dismantled. It's hard to see kids get worse. It's even harder to know that my once a week intervention is futile (Journal Notes).

Based on my observations, the primary power maintenance strategy of the new manager was to cede power to the kids. In addition, I never saw her take an active role in coaching and developing the new staff. In that context, I began to feel the power of my position slipping through my fingers. Without a core of naturals to back up my implementation of attentive empowerment and to intervene when our coworkers ceded power or used aggressive power, my efforts became strained and the program I helped to maintain for over a year collapsed right before my eyes.<sup>65</sup>

Interestingly, when I began hear about and actually witness direct-care workers being manipulated, tricked and duped, it wasn't so much due to the kids resisting the exercise of disciplinary power (see Foucault, 1977) as much as it was due to the kids taking advantage of a power vacuum. The new staff weren't exercising disciplinary power and they weren't engaging in attentive empowerment. While I could say they were ceding power, that would imply they understood how to maintain a position of authority while avoiding conflict. That's not what was happening here. They had completely lost the power of their position as the kids manipulated and

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<sup>65</sup> On 10/9/08, I wrote in my research journal "I felt reluctant to leave the job because I didn't want to abandon the kids to a program that was not running properly. I wanted to stay because I thought maybe I could help. I also wanted to leave because I felt powerless to fight the current tide. There isn't a single strong staff left from the old guard, and only one new staff is someone I would consider a potential strong staff."

tricked them into running the program how they wanted it to be run. When the core of Mountain View's naturals were replaced with weak staff, supervision of the kids went down, attentive empowerment all but disappeared, and the kids began to seize control. As Mountain View's staff lost power over the kids they were charged with keeping safe, the residents, the staff and the community were endangered more than ever.

### Thrown to the Wolves

Prior to stepping foot into any of ABC's group-homes, direct-care workers are expected to receive extensive training. According to Alex, "the way it's supposed to work is that you have initial training, which should be at least forty hours . . . then you have two observation shifts and then you're thrown to the wolves . . . (laughing)." Although Alex was being somewhat facetious, this aphorism did capture how many of his employees felt. As reported by Krystal, "I just feel like a lot of people are thrown into the deep end with that job and they either have to sink or swim." Luna referred to it as being "shell-shocked." Although being "thrown to the wolves" was not the type of experience my colleagues expected, it was the reality they encountered. Indeed, it was common for Mountain View's direct-care workers to experience occupational abandonment and unexpected agency.

Nevertheless, direct-care workers had to adapt to occupational abandonment; especially during crisis situations as they discovered that the training they received was unrealistic and the structure they expected to be there was often nonexistent. In this context, direct-care workers unexpectedly had to rely on their agency and they adapted by employing a variety of power maintenance strategies. Although attentive empowerment emerged as a safe and effective way for direct-care workers to maintain the power of their position and the dignity of the child, not

everyone had the ability—or the inclination—to help these kids deescalate. Unfortunately, some direct-care workers agitated the kids and made things worse.

For example, David told me about a direct-care worker who “didn’t really understand one of the kids and what he was going through and she made a bit of an issue with checking him at the door and he became upset and punched her in the jaw and broke her jaw and she was all wired up.” Tragically, when direct-care workers have to rely completely on their agency to negotiate crisis situations, some of them become endangered as a result. While some were able to figure out what works in practice, others employed strategies that endangered themselves and the kids they worked with. This endangerment was not only tragic: it was also systemic.

For instance, during my conversation with Alex, he revealed that “about half of the holds that we employ probably could have been handled differently. I’m not saying that they’re used as—you know—forms of control or abuse, but I do think that we probably could have handled the situations differently. So, that’s a focus for us, but I don’t think that they should be eliminated.” When I asked him if that was a training issue, he replied “yeah, it’s a training issue [but] not an initial training issue. I think it’s an ongoing assessment, feedback [issue].” In his opinion, “there should be a debriefing process . . . to critically examine what happened. But, I think a lot of time staff feel that they’re under the microscope: ‘I don’t want to get in trouble.’ And, that’s not the case. It’s more of a learning opportunity—you know. ‘What happened?’ ‘Could you guys have done [things] differently?’ We would document that.” Thus, while Alex was committed to examining how crisis intervention practices could be improved at ABC, he was also aware that approximately fifty percent of the holds could have benefited from a “debriefing process” that did not exist. In other words, Alex was aware that a substantial percentage of crisis interventions at ABC could be improved.

Interestingly, Alex also reported “I know for a fact that there’s agencies that lie about the number of holds that they had and how long they lasted. We won’t do that. But, I think that it’s important to kind of review that.” When I asked Alex if he was aware of holds being done inappropriately at ABC, he replied “yes” and explained “I think, with TCI, it’s a guideline. I would say close to a hundred percent of the holds probably—from a technical aspect—probably there are some things that we could have done differently. I mean, I just think it’s the nature of... (long pause). You know, they teach you the techniques, but again you have a child that’s behaving unpredictably . . . So, I think that I would say close to a hundred percent of the holds probably don’t go as they are . . . [taught] in the classroom. I would say—you know—again . . . it’s hard to really quantify, but I would say a good—maybe—twenty percent of the holds are used inappropriately. And . . . in one hundred percent of the holds that are used inappropriately—that we’re aware of—[they] are dealt with pretty severely. I mean . . . depending on the outcome—you know: termination, we’ve involved the police before, retraining, suspension . . . depending on what has happened.” Thus, while some agencies may lie about their numbers, Alex presented himself and ABC as forthright. In addition, Alex indicated that ABC takes this problem very seriously—when they are aware of it—as the company will go so far as to involve the police when necessary. However, the extent of ABC’s awareness is precisely what is most troubling.

Indeed, Alex surmised, “over the years, and again, I’m not just looking at ABC, I’m looking industry wide, . . . I’ve heard staff say things like ‘well, this is what they teach you, but this is what we really do in the home’ and that’s hard to combat. You have to be aware of it and when we are aware of it, we deal with that. Because, we’ve had that happen a couple of times within ABC where we have discovered that people are using the holds inappropriately and

there's collusion going on. You know, there's usually a group of staff that work together, cover each other, and we deal with that pretty severely." When I asked Alex if that was due to a lack of "oversight" or if it was "just unavoidable," he replied "I think—you know, again—you don't have your... (long pause). In this field, you don't have your supervisor standing over your shoulder all the time. When you're working direct-care, you're working with . . . one or two other people. You tend to form a close relationship with those other people; especially if you're fulltime. It's like a mom and dad. I mean, you're working pretty intimately with these people, so I think sometimes some things evolve over a period of time and I think that through the data collection you really try to pinpoint [what's going on]. You know, we've had situations where we have one staff in particular that's involved in multiple holds and that's usually a red flag for us. You know, we'll address that." In fact, Alex revealed "[t]hat happened with me when I worked direct-care. I was involved in a number of holds and I had my supervisors say 'hey, what's going on? Every time you're working, you're in a hold.' And it really made me think—you know—how often do I utilize these holds?"

By examining the number of holds practitioners are involved in, companies like ABC engage in *statistical surveillance* to keep an eye out for "red flags." Alex found this type of data collection and analysis to be helpful when it was used to monitor his own practices as a direct-care worker. Indeed, it made him think more about his own use of physical restraints. Nevertheless, it would appear that dangerous practices can escape statistical surveillance when there is "collusion" and there isn't a "supervisor standing over your shoulder." Thus, when companies like ABC monitor their practices primarily through the collection and examination of statistical data, they—wittingly or not—grant their practitioners ungoverned authority as their actual practices often go unobserved. Instead of monitoring the actual practices of practitioners,

companies like ABC monitor the data practitioners produce to account for their practices. Unfortunately, this can lead to the monitoring of a false reality: a statistical illusion (see Young, 2011). Although ABC may not lie about its numbers, there is nothing preventing its practitioners from finagling their numbers when actual surveillance is limited. In fact, by throwing its practitioners to the wolves and failing to directly monitor of how they interact with troubled youth, ABC is not only implicated in the creation of crisis situations, it also enables its staff to cover their tracks when they handle them in an abusive manner.

Nevertheless, Alex indicated “if you’re trying to hurt the child, that’s where we have no tolerance for that. I understand when you’re scared as a staff member and you’re dealing with a crisis situation, an aggressive child . . . things aren’t always going to go as they’re identified in the classroom and we work with that, but if you’re . . . (pause). You know, we’ve had some people that just use it as a form of punishment. You know, there’s no tolerance for that.” While it is hard to imagine how any behavioral health company would tolerate abusive treatment of its clientele, the zero tolerance policy Alex speaks of is unfortunately contradicted by the surveillance practices he attributes to “this field.” In practice, statistical surveillance tolerates everything that is not voluntarily accounted for when actual surveillance is absent. Not only can endangerment hide between these numbers, it is also likely to persist under this myopic form of surveillance. Tragically, statistical surveillance enables systemic endangerment to continue.

In addition, it would appear that the very logic behind statistical surveillance can also lead to endangerment. For example, when Luna revealed that she saw a direct-care worker intentionally hurt a kid at Mountain View, I asked her what happened as consequence? Luna replied, “the boy went to the hospital, we got dinged.” When I asked what happened to that direct-care worker, she revealed “that staff got moved over to another house; who then became

the [program coordinator] over there.” In her opinion, ABC treated it as “an isolated incident, but at the same time, how isolated was it? Was it just because he got caught that one time? Or was it because it truly was an isolated incident? And if it was, then retrain him. Don’t go send him back into a position of power without retraining him and that’s what happened.” Although Luna was concerned about how this worker might endanger the kids he worked with, ABC relied on the numbers that indicated this was an “isolated incident” because “that employee has been stellar this many months.” While it is possible this could have been an isolated case, Luna suggests it is also possible that other instances could have fallen through the cracks of statistical surveillance.

Moreover, even if ABC retrained this practitioner, it is far from clear that would have enabled him to handle crisis situations more appropriately. As previously indicated, TCI training was often experienced as a ruse at Mountain View. According to Krystal, “I feel as though the TCI training is just a certificate with your name written on it, as opposed to something that you can really say that you are like well informed and well trained on . . . [and] when you have staff members that don’t know what the hell they’re doing or are nervous . . . it is a big deal; you don’t want to hurt the boy and you don’t want to hurt yourself . . . TCI training is for the safety of them and others. So, it really depended—every single restraint—on who I was working with, on who the boy was—every boy was different—and there was some boys that we couldn’t even restrain.” Further, Krystal reported “one [direct-care worker] in particular, and definitely others, didn’t even know when a restraint should be enforced, which is . . . really important. . . So, that makes a difference also.” According to Dylan, “the angles of approach, . . . therapeutic crisis intervention, if you can’t do that correctly it’s a serious risk to injuring the children. Almost all of our staff would fail that.” When I asked Dylan if this was due to a lack of supervision or due to training,

he replied “it’s a combination, I think, of the structure of our house and poor training.” When I asked Luna about the training ABC provided, she referred to it as “a perpetual cycle of generic training that will never—ever—help anybody.” Indeed, this cycle of poor training—in addition to the lapses in actual surveillance—systemically placed the kids and staff in danger.

### Continuous Endangerment

In this case of systemic endangerment, it was ultimately power-maintenance—at the direction of the state—that was prioritized over ensuring the dignity of the child. The state enabled all of its providers—including non-profits—to deprioritize the dignity of the child when it failed to invest in meaningful oversight of the power-maintenance strategies of its providers.

Although ABC officially utilized TCI, when Timber tried to break into the sharps-closet at Mountain View, TCI was useless. He was simply too big to be restrained safely. Nevertheless, ABC can evade the criticism that it put Timber and the staff who had to restrain him at risk. ABC can point to the paper-trail that shows TCI is supported by research and it can show that its practitioners were trained. Indeed, Krystal pointed to the irony of having received training that appeared to be nothing more than an exercise in producing a paper-trail of propriety. In her experience, TCI training resulted in “a certificate with your name written on it” versus the acquisition of actual skills. Nevertheless, her “certificate” suggests that she can safely restrain the Timbers of the world.

While there are other restraint reduction programs that are considered to be evidence-based, ABC can demonstrate that it was also fully compliant with the state when it chose TCI. According to Alex, the training provided by ABC was “required by the state.” When I asked him what was specifically required, he replied: “all of it is required one way or another . . . For example, we have to train in emergency safety responses... (pause). We offer TCI. We could



offer CIT or whatever . . . So, we do have some ability to—you know—select what we offer . . . They tell you, you have to have something on . . . (pause) emergency situations, data collection, but they don't tell you what you have to train on. So, the company itself essentially develops the trainings.”

While the provision of a crisis intervention program was governed by the state, the selection of the specific program and the actual training that was provided were left ungoverned. That is, the state granted companies like ABC ungoverned authority to select and develop the crisis intervention training for its direct-care workers. In addition, it sanctioned the use of statistical surveillance—“data collection”—to monitor the implementation of its crisis intervention practices. In other words, no one was looking over the shoulder of ABC to ensure that its crisis intervention training was realistic, appropriate, or adequate and no one was checking to see if the numbers that were produced represented what was actually happening. When the state let its providers develop their trainings and decided to monitor their practices primarily through the collection of statistical data, it enabled practitioners to produce statistical illusions to cover up poor quality care. By enabling the production of statistical illusions instead of engaging in actual oversight, the state prioritized power maintenance over maintaining the dignity of the child.

Although my colleagues felt like they were abandoned to deal with crises in unexpected situations with insufficient tools, their experiences with occupational abandonment and unexpected agency remained undetected. While some of my colleagues used their agency to engage in attentive empowerment, some manipulated the kids, and others behaved aggressively.

<sup>66</sup> This aggressive treatment not only endangered the kids, it also subjected Native American communities to further suffering at the hands of the state. This exposure to aggressive treatment is all the more disturbing when considering that the majority of the kids at Mountain View were suffering from trauma.

Nevertheless, ABC can avoid claims of systemic endangerment and re-traumatization by pointing out that ABC did not sanction dangerous techniques. That is, it could lay blame squarely at the feet of direct-care workers who went outside of the scope of TCI. As stated by Alex, “TCI—really—is to protect the child and it protects the staff from liability, as well. So, I think that if you’re following all the techniques properly . . . and something does go wrong, you have the company [and] TCI essentially backing you up.” Implicit in this statement, is powerfully latent fact that ABC can also avoid liability when its practitioners go beyond the parameters of TCI. Although my colleagues reported that their TCI training left them unprepared, their certificates suggest otherwise.

While ABC may not have created its egregiously bad apples, they were allowed to remain rotten by the system of surveillance sanctioned by the state. Indeed, the state is ultimately responsible for the re-traumatization of these kids and their communities. However, ABC and the state can evade these critiques as long as the company continues to act swiftly on the “red flags” revealed in their data. Unfortunately, because there are no supervisors “standing over your shoulder” in this field, abusive treatment can escape detection as practitioners use numbers to

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<sup>66</sup> Ironically, the “dysfunction of power” that resulted from the lack of training and the lack of actual surveillance not only resulted in the emergence of mini-monarchs who were “sometimes lenient” and “sometimes over-hasty and severe” (see Foucault, 1977, p. 80), it also led to the emergence of empowering techniques that nurtured the ‘soul’—the inclinations—rather than producing “a ‘soul’ to be known and a subjection to be maintained” (p. 295).

conjure images of kids posing imminent harm. Not only does statistical surveillance create the illusion of monitoring and oversight (see Young, 2011), it also buttresses ABC's paper-trail.

Disturbingly, Alex indicated there are "agencies that lie" about their numbers. While the degree of distortion created by statistical illusions in this field is unknown, it is clear that a distorted view of reality is enabled by a paper-trail of propriety that takes numerical data for granted. When overreliance on statistical surveillance is considered along with the fact that restraints are "commonplace" and "largely unregulated" (Smith and Bowman, 2009, p. 59; see LeBel, et al., 2010), it becomes clear how the state enables providers to continuously engage in systemic endangerment and evade detection.

### Conclusion

Timber may have been destined to fall, but the insights of those who figured out what works in practice suggest that crises can often be averted and troubled youth can be empowered to deescalate. Nonetheless, I will always be haunted by questions. What would have happened had the company—as a whole—been more attentive to what was going on with Timber? Why didn't ABC make arrangements for him to visit his ailing mother? Would he have blown up if he was constantly surrounded by attentive and caring adults instead of being exposed to aggressive staff members? More importantly, why was he placed 100 miles from home? Further, what would news of a fourteen year old being thrown down to the ground by four adults mean to the reservation community he came from? Was this four-on-one take down of Timber part of a larger "treatment failure" (Curie, 2005, p. 1139)? The experiences revealed here suggest that it was and that it was the state that ultimately enabled systemic endangerment at Mountain View.

## Slumcare and the Fail-State

In the highly contentious arena of governance, many have argued that we are in a post-modern era (Gilmore, 2007, Simon, 2007; Young, 1999; Young 2011; see O'Malley, 2000). Gone are the days of widespread belief that governments can solve most of our social problems. Indeed, gone are the days of widespread belief that governments can be relied on to do much of anything. In fact, one could argue that a long and tenacious *war on governance* has not only led to the dismantling of the welfare state in the US, but also the rise of the neoliberal state; which increasingly looks to the private sector to manage our most pressing social problems.

Although critics of governance are widespread, the sources of criticism are diverse. Critics of the welfare state argue that welfare handouts create a moocher-class of government dependents. Instead of promoting self-determination and drive, welfare is criticized for enabling laziness and complacency (see Brown, et al., 2003; Garland, 2001; Gilmore, 2007; Muncie, 2005; Young, 1999). Critics of the racial state point to the tragic irony that a considerable portion of white middle class wealth was facilitated by handouts during the New Deal as the federal government selectively subsidized white flight from decaying inner cities while black families were systematically denied access to the suburban oases our government helped construct (see Avila & Rose, 2009; Highsmith, 2009; Massey & Denton, 1993; Sharkey, 2013). Moreover, it is argued that the policies of the Great Society failed to secure equal opportunity in the new post-

industrial economy as housing discrimination and employment discrimination proliferated in spite of the legislative victories achieved in the 1960s (see Bell, 1992; Delgado & Stefancic, 2001; Loury, 1998; Pager & Shepherd, 2008). Similarly, critics of the penal state have argued that the selective targeting of predominately black and brown communities during the war on drugs and the persistence of discriminatory treatment throughout the penal process has not only led to gross racial disparities in punishment (see Alexander, 2010; Beckett et al., 2006; Bridges & Steen, 1998; Engen, et al., 2002; Steffensmeier, et al., 1998), but has also led to the implosion of the ghettos our government policies created and then abandoned (see Clear, 2008; Roberts, 2000; Roberts, 2004). Although a wide spectrum of critics acknowledge that the penal state is presently in crisis, what appears to unify the left and the right in the US are concerns about its unsustainable costs (see Gilmore, 2007; Schulhofer, et al., 2011).

Indeed, the rise of the neoliberal state has been attributed to the proliferation of a cold and calculating “ethos of business management” (Garland, 2001, p. 116) and its concerns with managing the costs of our social problems as opposed to addressing their deep seeded causes (see Feeley & Simon, 1992; Muncie, 2006; Simon, 2007). In the realm of criminal justice, it has been argued that a *culture of control* has harnessed this managerial ethos and its concern with cost-effectiveness and engineered the emergence of a “third ‘governmental’ sector” (Garland, 2001, p. 170; see Simon, 2007). Positioned “between the state and civil society,” this *third sector* is composed of a plethora of private actors who have taken on the business of crime control “at a distance” from the state (Garland, 2001, p. 170; see Garland, 1996). The underlying rationale of this new form of “governing-at-a-distance” is that privatization and liberation of the market can lead to the most efficient and cost-effective crime control strategies (Garland, 2001, p. 126). Ultimately, the infusion of “managerial reasoning” into crime control has helped to produce a

growing industry that promises to “minimize costs and maximize security” (p. 175; see Feeley & Simon, 1992).

### Mismanaging Juvenile Crime Control

As an incubator of crime control strategies, our juvenile justice system is teeming with the latest and greatest technologies of this *third sector* (see Muncie, 2005; Muncie, 2006; Myers & Goddard, 2013). However, because the third sector is nestled between the state and society, its whereabouts can often be hard to detect. Indeed, it may come as a surprise to many that one of the most prolific sites for the growing industry of juvenile crime control is within the larger industry of privatized public healthcare (see Curran, 1988; Flaherty, et al., 2008; McCullough & Schmitt, 2000; Wells, 2006). In fact, a cornucopia of behavioral health interventions aimed at preventing and reducing juvenile crime are purchased by Medicaid managed-care organizations throughout the country (see Callahan, et al., 1995; Cook, et al., 2004; Hutchinson & Foster, 2003; Kim and Jennings, 2012; Tang, et al., 2008; Reid, et al., 1996). These managed care entities—which are responsible for managing a capitated amount of Medicaid dollars—contract with private vendors that sell a variety of brand name and generic therapeutic practices to address the behaviors of troubled youth and then pocket whatever Medicaid dollars are not used in the process. That is, they profit from spending—or, more to the point: not spending—Medicaid dollars in the most cost-effective manner possible.

While it may be concerning to some that this *third sector* of juvenile crime control is profiting off of Medicaid—that is, taxpayer—dollars, it is based on the premise that competitive bidding and contracting in this industry will lead to more cost-efficient interventions without sacrificing quality (see Freeman and Kirkman-Liff, 1985, Kirkman-Liff, et al., 1987, McCall, 1997, Rosenblatt, 1985). With names like AHCCCS (pronounced as *access* in Arizona),

Centennial Care (New Mexico) and TennCare (Tennessee), Medicaid managed care entities across the country telegraph their intent to facilitate access to quality care. However, the progenitor of the Medicaid managed-care revolution—the Arizona Health Care Cost Containment System (AHCCCS)—wasn't exactly subtle about its core objective: *cost control* (Rosenblatt, 1985). Nevertheless, the neoliberal theory guiding AHCCCS and its progeny is that cost control can be balanced with access to quality interventions through the magical workings of the market (Rosenblatt, 1985). Indeed, the stated intent behind programs like AHCCCS was to 'provide high quality care to the poor in a cost-effective manner' (Rosenblatt, 1985, p. 951). In this 'radical experiment,' Arizona and the federal Health Care Financing Administration "turned to the private sector with a strong believe in the capacity of competitive bidding and for-profit management to achieve success, quality, and cost-containment goals" (Rosenblatt, 1985, p. 952).

True to its maverick identity, Arizona was the last state of the union to participate in Medicaid in 1982 and it was the first to revolutionize its delivery via the private sector (Freeman and Kirkman-Liff, 1985, Kirkman-Liff, et al., 1987, McCall, 1997, Rosenblatt, 1985). While AHCCCS got off to a rough start in Arizona, early studies indicated it was achieving its cost reduction goals (Rosenblatt, 1985). In 1992, Massachusetts followed Arizona's lead and became the first state to implement a "statewide" Medicaid managed care system for mental healthcare (Callahan, et al., 1995, p. 174). This revolutionary form of governance then spread like wildfire throughout the nation as the number of people enrolled in Medicaid managed care "more than quadrupled" in the early 1990s (Gold, et al., 1996, p. 153). By 2000, "42 states" instituted Medicaid managed care systems to meet the behavioral health needs of its most vulnerable and least fortunate citizens (Tang, et al., 2008, p. 883). By 2008, 70 percent "of the Medicaid population was enrolled in managed care" (Kim and Jennings, 2012, p. 815). Presently, the use

of Medicaid managed care is “expected to increase with the 2014 Medicaid expansion under the Affordable Care Act” (Caswell and Long, 2015, p. 1).

While studies continued to promote the cost-reduction benefits of Medicaid managed-care in behavioral health, quality concerns were raised early on and this was particularly true in relation to the quality of care provided for children (Callahan, et al., 1995; Cook, et al., 2004; Hutchinson & Foster, 2003; Reid, et al., 1996). In fact, as adoption of Medicaid managed care in behavioral health spread rapidly across the country, it was noted that “[c]hildren generally have been overlooked, not only in the development of managed care models, but also in evaluations of managed care plans” (Hutchinson and Foster, 2003, p. 39). Alarming, a review of the literature in 2003 found that “[n]one of the reviewed studies included a direct measurement of outcomes or quality of care” for children (p. 50).<sup>67</sup> However, in a 2008 study, it was found that children living in states with Medicaid managed care had “greater reported unmet need for mental health care” than those living in states with traditional Medicaid (Tang, et al., 2008, p. 895). In 2010, a nationwide study of children in our child welfare systems found that “only half” of these children received mental healthcare that was “consistent with at least 1” national standard (Raghavan, et al., 2010, p. 746). Thus, it should come as no surprise that child advocates have been suing state Medicaid administrators across the country to redress the failures of their managed-care systems (Land, 2003; Mello, 2002; Scaparotti, 2007; Somers and Perkins, 2007).

Indeed, the Medicaid managed-care revolution came full circle when a class action lawsuit was brought in 1991 on behalf of children in the state where it all began: Arizona (“Arizona Vows,” 2001). In Arizona, advocates claimed that the state failed to provide impoverished children with “medically necessary mental health services” (J.K. v. Dillenberg,

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<sup>67</sup> In fact, managed care has long been plagued by inadequate information on quality care as “[c]ost, rather than quality, drives marketing of plans” (Cerminara, 1998: 19).



1993, p. 696). Although the Arizona Department of Health Services (ADHS) argued that it should not be held liable for the actions of its subcontractors, the Honorable John M. Roll proclaimed “[i]t is patently unreasonable to presume that Congress would permit a state to disclaim federal responsibilities by contracting away its obligations to a private entity” (J.K. v. Dillenberg, 1993, p. 699). In 2001, a “groundbreaking” settlement was reached which was ‘the first to overhaul a state mental health system that operates on a managed care basis’ (“Groundbreaking Reform,” 2001). As a result of this settlement agreement, the parties sat down and penned the “Arizona Vision” for “improving the quality” of behavioral health services for children “with the goal of enabling children ‘to achieve success in school, live with their families, avoid delinquency and become stable and productive adults’” (“Groundbreaking Reform,” 2001). In 2006, the reform deadline was extended for another three years due to ‘lack of progress’ and claims that ‘children still lack access to the home- and community-based services that can help them’ (“Court Sets Three-Year Extension,” 2006). In 2009, litigation was renewed due to the “glacial pace” of implementing the *Arizona Vision* (“J.K. v. Humble,” n.d.).

In a tragic turn of events, the Honorable John M. Roll was shot and killed in 2011—along with five other people—by Jared Loughner when he was attempting to kill Congresswoman Gabrielle Giffords at a meet-and-greet in Tucson (Gassen & Williams, 2013; Lacey, et al., 2011). Like many mass shooters who have wreaked havoc across the US, Loughner was a disturbed young man who appears to have fallen through the cracks of our mental health system. At the time of the shooting, the 22 year-old was apparently suffering from schizophrenia, yet was not receiving any treatment (Feng, 2012; Gassen & Williams, 2013). Disturbingly, it was reported that in 2010 Loughner “didn’t get a mental health evaluation even after Pima Community College officials recommended it” (Corella, 2013). In the aftermath of the shooting, it was noted

that “[w]hile the media immediately seized upon Loughner's mental illness, the less-covered story is the alarming state of Arizona's mental health system” (Feng, 2012, p. 543).

However, Arizona is far from being the only state in the union with a troubled mental health system. Nor is it the only state where child advocates have used litigation in an attempt to achieve meaningful reforms. In fact, by 2001, “lawsuits against twenty-eight states” alleged that Medicaid managed-care was failing to meet the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) needs of children as required by the Medicaid statute (Mello, 2002, p. 466; see Luke, 2009; Scaparotti, 2007).

In Massachusetts, for example, child advocates joined the fray when they claimed that Governor Mitt Romney and the administrators of the state’s Medicaid managed care system “failed to provide medically necessary EPSDT services to . . . thousands of disabled low-income children” (Rosie D. v. Romney, 2006, p. 22). In particular, it was alleged that “medical assessments and coordination of needed services for children with serious emotional disturbances” were “inadequate or non-existent” and that “in-home behavioral support services” were also “inadequate or non-existent” (Rosie D. v. Romney, 2006, p. 23). In 2006, a US District Court judge in Massachusetts found that “thousands of needy SED children [children with serious emotional disturbances] lack comprehensive assessments; treatment occurs haphazardly, with no single person or entity providing oversight and ensuring consistency” (Rosie D. v. Romney, 2006, p. 23). In regard to in-home services, the judge found that “Defendants fail to provide these services adequately. The result of this failure is that thousands of Massachusetts children with serious emotional disabilities are forced to endure unnecessary confinement in residential facilities, or to remain in costly institutions far longer than their medical conditions require” (Rosie D. v. Romney, 2006, p. 23). Alarming, the judge concluded that the failure to

provide needed services “was glaring from the evidence and at times shocking in its consequences” (Rosie D. v Romney, 2006, p. 24).<sup>68</sup>

After the District Court of Massachusetts found the defendants liable for their failure to provide adequate behavioral healthcare, it then adopted the state’s remedial plan in 2007 and appointed a Court Monitor to “oversee the implementation” (Rosie D. v. Patrick, 2007, p. 27). Although a statewide review published in 2015 found that on-the-ground practices were still falling short in a number of key areas, it also found that the state was making a concerted effort to improve access to services and to provide them in the most appropriate and least restrictive setting possible (Technical Assistance Collaborative, 2015; see Kuhlthau, et al., 2011; Romano-Clarke, et al., 2014). Further, studies have found that behavioral health screening and treatment have increased significantly since the 2006 District Court decision (Kuhlthau, et al., 2011; Romano-Clarke, et al., 2014). Indeed, reform litigation appears to be achieving a gradual “transformation of the children’s mental health system in Massachusetts” (“Goals and Objectives, n.d; see Center for Health and Health Care in Schools, 2013). However, this appears to be an exception to an otherwise grim state of affairs.

Clearly, “the failure of the states to properly execute the EPSDT provisions is unjustifiable” (Luke, 2009, p. 752). However, the Secretary of Health and Human Services (HHS) and the Federal Courts have limited authority to enforce the Medicaid statute (Grusin, 2015; Luke, 2009; Mello, 2002; Scaparotti, 2007). While the Secretary of HHS has the authority to withhold funds given to the states, this would cause more harm than good (Grusin, 2015; Luke, 2009). Although the Centers for Medicare and Medicaid Services (CMS) have been given

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<sup>68</sup> Further, the District Court judge cited Judge Roll’s 1993 decision in Arizona for the proposition that states ‘may not ignore the Medicaid Act’s requirements in order to suit budgetary needs’ (Rosie D. v. Romney, 2006, p. 25).

“oversight responsibilities” within HHS, these federal agencies have been hobbled by the war on governance (Mello, 2002; 469; see Grusin, 2015). Not only has Congress underfunded CMS, but the Reagan, Bush, and Clinton administrations “have weakened agency regulation” by supporting neoliberal policies that emphasize “cost cutting, and efficiency of operations over the achievement of substantive regulatory goals” (Mello, 2002, p. 470). In fact, “[t]he agency has never received funding sufficient to fully enforce the Medicaid requirements against the states” (Grusin, 2015, p. 343).

Further, out of respect for state sovereignty, the US Supreme Court has “ruled that courts should defer to remedial decisions made by state agencies” (Scaparotti, 2007, p. 214, citing *Lewis v. Casey*, 1996). Discouragingly, “[e]ven when the parties reach a settlement, the state does not always provide the needed programs due to budgetary and administrative restrictions” (Scaparotti, 2007, p. 213). Hence—as exemplified by the lawsuits in Arizona and Massachusetts—the outcomes of *successful* litigation can be quite diverse (Center for Health and Health Care in Schools, 2013). Indeed, court ordered remedies “often leave plaintiffs with insufficient relief” (Scaparotti, 2007, p. 210). Ultimately, successful outcomes appear to require *both* success in court and the willingness of the state to *govern* (Land, 2003; Scaparotti, 2007). Thus, while “there is a broad consensus that improved policing in some form or another is needed” in Medicaid managed care and while it is acknowledged that litigation can serve a “signaling function” and put the state on notice that reforms are needed, it is presently up to the states and their agencies to implement meaningful reforms (Scaparotti, 2007, p. 467, 485, see Land, 2003).

Unfortunately, states across the US continue to fall short in their provision of EPSDT services. Ironically, this often leads to what is referred to as the *stuck kids* problem, whereby

troubled youth end up being placed—or kept—in costly out-of-home settings simply because less costly in-home or community-based services are not available (Scaparotti, 2007; Weithorn, 2005). Although the providers of out-of-home services may profit from this state of affairs, the failure of managed care entities to contract for in-home and community-based services that cost less—and are actually more effective—is clearly a head-scratcher. Truly, something other than rational calculations of the market are at work when managed care systems fail to deliver the most cost-effective interventions in juvenile crime control. In fact, the third sector seems to be infested with mismanagement.

### The Limits of Neoliberalism

To a degree, the reforms achieved in Massachusetts indicate that at least some states are willing to put on their governing boots and rein in neoliberalism. In fact, on the heels of the lawsuit in Massachusetts, child advocates in Connecticut worked with the state’s Medicaid agency to implement meaningful reforms in mental health screening without having to resort to litigation (Grusin, 2015, citing Sicklick, 2013). Thus, it would appear that a *culture of care* has not only driven reform litigation in places as diverse as Massachusetts and Arizona, but it has also motivated state actors in places like Connecticut to institute reforms without being told they have to by a judge. Further, to the extent that child advocates have tamed the mismanagement of Medicaid managed care entities, they have also exposed the limits—and contradictions—of neoliberalism (see Gilmore, 2007; Kingfisher & Maskovsky, 2008, Muncie, 2006). While the “profit motive” in Medicaid managed care clearly “fosters cutbacks in care” (Cerminara, 1998, p. 10), the failure to invest in quality in-home and community-based interventions costs taxpayers more in the long-run as troubled youth get stuck in expensive institutional settings. Moreover, it would appear that an *ethos of care* can lead to policies that are more rational; especially when

state actors are emboldened to fight for quality interventions and meaningful oversight in their managed care systems. In addition, to the degree that neoliberalism champions market principles, it would appear that its reach into public healthcare has sown the seeds of its own demise.

Although successful litigation does not always bode well, it is clear that healthcare consumers across the country have refused to be governed by market principles that militate against the provision of quality interventions that cost more in the short-term, but significantly less in the long-run. Indeed, privatized public healthcare does not have to result in poor quality care within the third sector of juvenile crime control.

In addition, it is important to recognize that while the third sector has certainly introduced a managerial ethos into juvenile crime control (Garland, 2001), it has also introduced an ethos of care as many of these private actors are organizational hybrids that attempt to balance profit with care, control with empowerment, and security with dignity (see Goddard, 2012; Muncie, 2006, O'Malley, 2000). Moreover, it has been shown that neoliberalism is not the monolithic effigy of the market it is often made out to be (Goddard & Myers, 2011; Lobao, et al., 2014; Morgen & Gonzales, 2008; see Muncie, 2006). For example, neoliberalism has opened up spaces for “progressive local solutions” to flourish alongside market solutions to juvenile crime control (Goddard & Myers, 2011, p. 666; see Muncie, 2006). In addition, it has enabled community-based-organizations to conceptualize risk management both in terms of youth who are “facing problems” that need to be addressed and youth who are “posing problems” that need to be controlled (Goddard, 2012, p. 358). If the devolution of juvenile crime control to the third sector has attracted a host of hybrid organizations, what enables these hybrids to pursue one set of priorities over another? If neoliberalism is porous enough to permit social justice interventions to

thrive alongside the mismanagement of behavioral interventions, what are the exact processes within its loose structuring that enables poor quality interventions to persist in the third sector?

In the remainder of this chapter, I will explore on-the-ground experiences of how poor quality interventions persist in a for-profit behavioral health group-home for troubled youth.<sup>69</sup> In particular, I will show how this hybrid organization—which attempts to balance profit with the provision of care within a Medicaid managed care system—has degenerated into an institution that provides slumcare: that is, the provision of substandard care to the poor. In the process, I will demonstrate how experiences of slumcare thrive within the *fail-state*: a form of governing that repeatedly fails to achieve its mandate.

### Slumcare

At ABC, it was commonly understood that this behavioral healthcare company was *of two minds* (Luhmann, 2000). There was a therapeutic side to ABC and a business side. In other words, it was a hybrid organization. Ideally, its two orientations—along with their logics and priorities—should be balanced so that the provision of quality interventions would not tank the business and so that the pursuit of profit would not sacrifice quality. In terms of design, Tina—the regional director—reported that ABC was structured so that “the clinical director . . . has control over the therapeutic side . . . [and] the CEO has control of the business side.” As revealed by Gary, Mountain View’s trainer, “ideally, it should be just like the checks and balances of like the Congress and the Senate [sic]. . . so that they check each other . . . and here’s the thing, the outcome needs to be for the client, which is our kids...” Echoing this sentiment, Daisy—Mountain View’s therapist—stated “it’s all checks and balances and it all has to work in synchronicity or it’s not going to work at all and it’s difficult.” Although ABC promised the state,

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<sup>69</sup> In this regard, it is an exploration of a setting “where neoliberalism has ‘touched down’” (Kingfisher & Maskovsky, 2008, p. 121).

its managed care contractors and its impoverished clients that it could achieve this balance and deliver therapeutic juvenile crime control, my colleagues revealed that what they experienced was the provision of substandard care to the poor: what I call slumcare.

In Daisy's experience, "we don't have the checks and balances, for whatever reason." She explained, "it's a for-profit organization and there's a huge... (pause). It's an inconsistency. They say that—you know—we're here for the kids, we want to help the kids, yet I don't see where that's happening a lot of the time." When I asked Daisy what she thought the primary goal of the company was, she responded: "well, we're a for-profit organization." When I interjected "so, profit?," she answered, "yeah, it's a for-profit organization. Their goal is to expand and grow." Frustrated, she added: "[t]here are so many things that we could do differently. There are so many things . . . We could improve the houses quicker. We could—you know—provide more for the kids. I think that we could do more for the employees to make them happy and then make the kids happy... I would say the main goal is profit." Similarly, David—the most senior direct-care worker at Mountain View—told me "well, the main goal of any company is to make money." He added, "it was probably set up as a great way to help out people, but—I mean—the people in charge of the company are there to make money." Like Daisy, David also struggled with what seemed like a troubling organizational conflict. In his opinion, "in some companies where you're actually producing something, it probably wouldn't be that big of a thing, but in this company—at least—you're dealing with kid's lives, which is much more valuable than quotas of say beer or soda or something." When I asked Dylan—they day program coordinator—what he thought the primary purpose of the company was, he told me "well, if I was required to tell an administrator or I was reading it off of their policies, it would probably be something like treating kids—you know—enabling them to move to a lower level of care or move back in with their families. But,



what everything else shows is their primary objective—or their mission—is to make money.” Likewise, Gary lamented that—in terms of goals—it was clear that ABC was about “making some money.” While there is nothing wrong with making money and nothing inherently sinister about making money via a privatized social service, my colleagues were troubled by the fact that ABC seemed to care more about making money than helping out kids. As David put it, when “kid’s lives” are at stake, the prioritization of profit can be problematic.

Although the therapeutic side of ABC was intended to counterbalance the business side, Tina reported that “[a]s far as checks and balances, zero exist.” As she put it, “the communication between the two main brains is not the same at all. The ethics aren’t the same at all.” Ultimately, Tina summed it up as “snaky business, if you want to know the honest-to-God truth. And you’re just getting straight Tina’s personal opinion. My personal opinion is some individuals are in it just for the money.” When Tina finally identified the CEO as the individual she had in mind, she reported that he has “control over enough of the company that he’s a puppet-master. He can make anybody else dance the way that he wants them to dance.” According to Luna—the group-home manager—“I think the purpose of the company was—in the very beginning—true, in that they were really geared to try to help these kids, but I think that the political bullshit just really screwed up that entire goal. I think it was all about job security. Why help them? If we help them, then they’re going to be gone. But, it also didn’t help when you had an idiotic CEO that only thought about money and not about helping the boys.”

Despite having an organizational design intended to balance the therapeutic side with the business side, Luna and Tina believed something was off kilter at ABC. According to Tina, Alex was pulling strings in his favor and offsetting the balance. According to Luna, the mission of the organization was “true,” but the CEO apparently had other priorities in mind. Because the

business and therapeutic sides of this hybrid organization were not balancing each other out, Gary believed it's the kids "who [are] suffering from it." In Tina's, Luna's, and David's estimation, it was the people in charge who had tipped the scales towards slumcare.

However, as my colleagues revealed their experiences with slumcare, it became clear that the provision of substandard care was a product of both the structure they operated under and the agency of key individuals (see Bhaskar, 1989). In fact, it would be overly simplistic and illogical to blame slumcare, exclusively, on the neoliberal structure of the state as ABC and its contractors were marked by inefficiency and mismanagement rather than cost-efficiency and managerialism. Although it would be easy to portray Alex as the villain here, the stories my colleagues shared with me paint a more complicated picture: one that implicates both the loose structure he operated under and the choices he made. To demonstrate how the loose structuring of ABC enabled "snaky" practices to thrive, I will now turn to a variety of slumcare practices at Mountain View that were associated with *filling beds*.

### Filling Beds

As indicated in Chapter 1, Alex experienced the balancing of profit with the provision of services as the toughest part of being CEO. During my interview with Alex, it was clear that he struggled with this precarious task. In addition, it was clear that Alex wasn't a CEO that "only thought about money." Although Alex had an MBA and was business-oriented, he was *of two minds* (see Luhrmann, 2000). As he tells his story, he fell in love with psychology as an undergrad, worked his way up in a behavioral healthcare company, struggled with the fact that his employer seemed to care more about money than quality of care, and started ABC with an idealistic vision of providing a higher quality of care than what was presently available. In

addition, Alex appears to have manifested his vision as he proclaimed that ABC had the best ratios in the state.

According to Alex, “I was never interested in [the] MBA.” However, he believed that a successful CEO in this field should have both a behavioral health background and a business background. In his words, “I think a good executive director is going to have a lot of behavioral health experience and you really need some business background.” In other words, the ideal candidate to run this hybrid organization is a CEO who is also a hybrid: someone who understands the managerial ethos and the ethos of care. When Alex told me he “went back and got my MBA,” it was to help him fulfill his vision of running a behavioral healthcare company that would not sacrifice quality care. Yet, he also acknowledged that achieving the right balance of profit with care was “hard sometimes because—you know—again, being for-profit, that’s what the ultimate goal is.” Although Alex did not present himself as someone who “only thought about money,” he clearly understood that his company *needs* profit to survive. To be more precise, ABC needed to fill its beds in order to ensure company survival. The question is, does the built-in incentive to fill beds ultimately conflict with the provision of quality care?

#### Overextending the Market

According to ABC’s treatment philosophy, *family focused* interventions are key markers of quality care. At ABC, this includes family visits to the group-home, home passes for the residents, family counseling and monthly child and family team meetings (CFTs). Moreover, ABC advertises on its website that it has purposefully located its group-homes in the communities they serve in order to facilitate family participation. However, this apparently didn’t apply to many of Mountain View’s Native American residents as the group-home was often located 100 miles or more away from their families.

Timber, for instance—who was well over 100 miles from home—never had a family visit or a home pass the entire year and a half that I worked at Mountain View. And, he was not alone. Although one of our Native American boys did have periodic visits with his family, most of them did not as transportation challenges were often cited as major obstacles for those who lived on the reservations.

According to Luna, who identifies as half-Eagle, ABC did not have any contacts within the Eagle or Bear Tribes when she began working with them. However, because Luna did have professional contacts within both of these Nations, she reported that “in the latter six months of me being there, there was a lot of marketing on my part to get the monopoly on the reservations . . . We didn’t have a lot of the Native American boys coming in until . . . we actually got a hundred and seventy five thousand dollar contract with the Bear Nation and we got a two hundred thousand dollar contract with the Eagle Nation.”

However, Luna reported feeling both conflicted and used. As she tells her story, “my main focus was to get houses on the reservation, not bring them here. Keep them there where . . . (long pause). My main point was let’s build houses out there.” However, instead of remaining consistent with their treatment philosophy and establishing group-homes within the communities they served, ABC contracted with the Bear and Eagle Tribes to send kids far from their homes. Thus, instead of facilitating family participation, ABC hindered the ability of many Native families to participate in the treatment of their children as the company placed their children far away.

When I asked Luna if this arrangement was about getting kids better and providing them with needed services, she replied “it was never about getting the kids better. It had nothing to do with that. It was all about that profit margin. It was all about spreading marketing for ABC. It

was all about getting the foot in the doors where they were never able to go—ever—for eight years . . . So, it was about, ‘you know what, I’m gonna ride that horse for as long as I can.’” Further, once Alex had access to Luna’s professional contacts, “it was like, ‘alright, well, we got it now, we don’t need you . . . you’re rocking the boat too much. Hit the road.’” After Luna was fired, I wrote in my research journal what Luna had revealed to me:

[Alex] was mad at her for not giving him her Native contacts. She told me that he had an IT person go through her files to find the contacts. He did get some, but not the most important ones. Was this ‘insubordination’ an act of not helping the boss gain future clients? Where—in all of this—is the concern for the best interests of the kids? Right now, I feel embedded in the rotten core of a polished fruit (Journal Notes).

During my interview with Luna, it was clear that she was resentful of Alex and felt like she was used for her contacts. In her experience, Alex cared more about extending ABC’s market into Indian Country than he did about providing those communities with quality care that was truly *family focused*. “It was always about, ‘alright Luna, where are we on this? Can you get us here? How much of that can you get?’ It was always a profit margin, always.” While it is possible that Luna is merely a disgruntled former employee, it was abundantly clear that many of our Native American kids missed their families deeply and were facing obstacles to family participation that many of our non-Native kids did not have to face. By overextending its reach, ABC prioritized the expansion of its market over the provision of family focused care for its Native American residents. In Luna’s experience, the logic of the market overrode the logic of care at ABC and when she fought for higher quality care for the kids she worked with, she was terminated.

Although it is unclear how much of ABC's expansion into Tribal land was driven by solely by market considerations as opposed to the provision of a needed service, it is clear that reservation kids at Mountain View did not have the same type of family focused interventions as most of the non-Native kids. By its own standards, ABC overextended its reach and provided poor quality care to most of its Native American clients. When the company decided to sacrifice family focused care for the sake of expanding its market, it engaged in slumcare.

Although the built-in incentive to fill beds was a key factor here, Luna suggested that establishing group-homes on the reservations was a possibility. Thus, it would seem that ABC could have expanded its market without overextending its reach. While the logistics of this possibility weren't discussed, Luna clearly believed ABC could have remained consistent with its vision of quality care had it followed through with her suggestion and established group-homes "on the reservation."

### Keeping Kids

In addition to overextending ABC's reach, Alex also pushed his management team to keep the beds full. In Gary's experience, "[i]t's more like—I hate to say it, but it's more like—'how many beds do we have full' rather than 'how many kids are we taking care of' because this is still a for-profit organization." According to Luna, "from a CEO point of view," her primary duty as a group-home manager was "keeping the house full." As she explained, "every manager had to keep the capacity of that house [filled to bring in] at least thirty-five thousand a month . . . That was what our projected revenue had to [be] from each manager. If that manager didn't do that, then it took away from this, this, this, and this. So, then obviously it's always going to be the manager that's going to get canned if we don't have money coming in." In sum, Luna understood "[y]ou gotta have it full. You gotta have that house eighty-five percent full every

single month . . . and if that didn't happen, every month we would have—or every week we'd have—our general ops meetings where it's like 'alright, this is where we're at, this is what we had to do, why didn't you do this, why did you do this' and it was always a battle. And it's going to be a continual battle because money is involved.” When I asked Luna if there was ever any pressure to hold onto kids longer than necessary, she reported “ah-hm. I can think of two right off the bat; right off the top of my head... [B]ecause of their diagnosis and because of subsidiaries coming in, we actually got seventy-five hundred a month for those two boys . . . [and] I was told, 'keep them, keep them' . . . which is why I think the decline [in their treatment] really escalated because they weren't getting help.”

At Mountain View, there were frequent discussions among the staff as to whether or not the two adolescents Luna was referring to were appropriate for the level of care we could provide. Both of these residents had been at Mountain View for over a year, neither of them had families to go back to, and they both seemed to be getting worse over time instead of better. While there were periodic discussions that ABC was looking for alternative placements, those discussions seemed to go nowhere. While I had assumed this was due to a lack of alternative placements, Luna's statements reveal that—in her experience—ABC was intentionally dragging their feet to keep the revenue they were receiving for these kids.

When Daisy first started working with ABC, she reported “I was told that 'okay—you know—this is what we're after. This is what we shoot for. We want to make the kids better. We want to make sure that they get out of here and make it home and continue to do well. We want to help them.' Well, when suggestions have been made it's obvious that—you know—some kids don't need to be here as long as others and when suggestions have been made at meetings, saying 'okay, I'd like to see little Johnny, or whatever, be discharged because he doesn't need to be here.

He should be home with his parents. You know, they're doing what they need to do. He's doing what he needs to do.' Let's say the house is short two kids. I will be told—in no uncertain terms—that 'no, we need to keep the houses as full as we can.'" As she explained, "I was reminded that this is a for-profit company and . . . one person . . . said, 'well, if we're going to do that, than we might as well just shut houses down' and I remember we kind of got into it and I said 'wait a second, I'm just saying that Johnny needs to go home because [his] parents want him home and he's doing well. He needs to have an opportunity to be in a normal environment because he was one of the few kids that family therapy was working on. Mom and dad were involved. They wanted him home. He wanted to go home. And we are under an ethical obligation to see that he gets home' and I was told that 'no, we're low and as soon as we get more referrals, then we can look at getting Johnny home' and we got into an argument. I said 'how is that ethical? How is that even close to being ethical?' And, like, 'it doesn't matter, because we're looking at profits.' And like, 'oh, well, I'd love to see you say that at a CFT.'" Looking back, she indicated "I think that's one of the first times that—you know—Daisy wasn't the bright and shining star . . . that she was beginning to be a thorn in their side and I was like, 'well I'm sorry, if I have something on my mind, I'm going to say it, and this is BS.'" When I asked Daisy how often this sort of thing happened, she replied "it's happened occasionally... [E]ver since that happened, it hasn't happened to that degree, but we're reminded quite frequently at meetings that you only have five kids or we need to do this, or we need to keep these beds full because we need to make more of a profit and that bothers me because I'm thinking 'okay, so which one is it? Are we in the business of helping kids or are we in the business of helping upper management make more of a profit?'" To the say the least, Daisy was troubled by the prospect of *keeping kids* longer than necessary.



Given the pressure to keep the houses full, I asked Daisy if she ever went against her clinical judgment? Daisy responded, “unfortunately yeah, I’ve had to because—you know—when you’re subtly reminded . . . ‘just remember—you know—people’s jobs depend on this’ . . . I don’t do well with. I don’t believe in threats. I think that threats are crap. I pretty much had to keep them here for a while . . . but, then we said ‘okay, let’s work on some new skills. Let’s do this. Let’s get more family therapy going.’ And so we tried to make it into a positive thing, but also, what they seem to forget and . . . what I told the parents at the next CFT was that they ultimately had the decision of taking their child out of here when they felt it was appropriate...” Daisy added “they could do that at any time and they ultimately did that and so that didn’t make the uppers happy, but I’m just like ‘you know what, I’m not in the business of making you happy. This child is my first concern’ . . . But that bothers me. It just...(pause). It bothers me... When there’s a degree, in my opinion, of dishonesty—and just crap—then there are things that can be done at CFTs . . . you can always say, ‘as the guardian, or as the parent, you can decide if the child should not be in the program and if you want to come and get them today, you can.’ And, I have done that.”

Clearly, the practice of keeping kids who are ready to go home is unethical. In addition, it is clearly harmful as the literature is replete with the negative consequences associated with children being placed in restrictive out-of-home settings (see Rautkis, et al., 2011; Schoenwald, et al., 2000; Stone, 2007). Referring to this slumcare practice as poor quality care is an understatement. While it is unclear precisely how often this practice occurred, the pressure to keep the houses full was frequent and—at the very least—it appears to have happened “occasionally.” Although Daisy resisted the pressure to keep kids when it wasn’t necessary, she also capitulated when she “tried to make it into a positive thing” and found ways to provide more

services until the next CFT. However, as she described the pressure she faced, it wasn't to keep Johnny as long as possible, it was to keep him until another referral came in. In addition, when she was "reminded" that jobs depended on this, the message she was receiving was one of company survival: ABC needed beds to be filled to remain a viable company. The implication is that ABC could remain viable if they had enough referrals. Thus, the built-in incentive to fill beds doesn't have to lead to the slumcare practice of keeping kids. Based on what Daisy reported, the pressure to engage in this unethical practice derived from the fact that ABC had simply grown beyond the supply of troubled youth in the area. Indeed, Alex indicated in his interview that after opening six group-homes in seven and half years, the company had reached its limit and it wouldn't open another one. Thus, it appears that ABC's management pressured Daisy and Luna to keep kids longer than necessary so the company could sustain its oversized growth. If Alex had kept the company small, this may have never occurred.

#### Capitalizing on Stuck Kids

Although direct-care staff had no authority over the length of stay of the residents, the slumcare practices associated with filling beds trickled down to their everyday experiences. However, this experience was muddled by the fact that ABC was also dealing with a stuck kids problem. For instance, when Dylan told me that he believed the primary mission of ABC was to make money, he explained that it was "to fill the beds in the house." He explained, "it's the fox guarding the henhouse. Our mission is to discharge kids into a lower level of care and have them leave, but when we do that we lose money." When I asked Dylan if he ever thought kids were kept at the group-home for profit, he responded "yeah, I believe we occasionally have kids that this isn't the right place for them, yet they're kept here. But, I believe . . . part of that is because we would like to fill a bed and earn their money—their monthly check—and, at the same time, I

believe it's because the behavioral healthcare system—as a whole—doesn't have a place for these guys.” When I asked Dylan if it was possible that this was just a placement issue as opposed to an issue of holding onto kids for profit, he indicated “I've seen examples of both. I think for some kids, it started off where—you know—this kid is a liability if we have him. He's dangerous in our house, but there's nowhere else for him to go and we'll make money so let's keep him here.” I asked Dylan if he heard these types of discussions among upper management and he stated “I have seen it implied through faxes and verbal statements and just the actions of others.” Similarly, David reported that “people in the company don't get the kid out nearly as quickly as they should; especially when they start seeing some of the warning signs. I mean, one kid, I've heard that one of the managers of the company said to the RPD ‘the only reason why we have this kid is to make money for the company.’” In addition, David experienced kids being stuck at Mountain View because of “the politics of the system.” As he put it, “outside agencies drop the ball repeatedly.” David found this experience frustrating because it affects the kid and “you just have no control over [it].” For example, David revealed “one of the residents that I deal with currently, he has been at the house for over three years and he should have been gone probably about two and a half years ago; two years ago. But, the agency that's supporting him continues to drop the ball and refuses to grant him money to go.” David acknowledged “I think he might be the exception. But, there's also a lot of houses out around the country similar to this. So, how many other kids are falling through the cracks because some bureaucrat doesn't want to give this kid some money.” In Lance's experience, “I had a kid here for a while—until he got discharged—I didn't even see why he was in the program. He was here and I never really saw him have any kind of challenges or anger outbursts.” In addition, Lance reported “certain

residents shouldn't be here. They definitely need a higher level of care. Some of them should be at a lower level of care.”

At Mountain View, direct-care staff not only experienced the stuck kids problem, they also experienced ABC capitalizing on it. As revealed by Lance, David, Dylan, and Luna, Mountain View held onto kids who were perceived to be potentially “dangerous” and beyond the caring capacity of the group-home. Although these kids were in need of intervention—as opposed to being ready to go home—ABC capitalized on the slow wheels of bureaucracy and the limited options that were available. Indeed, the pressure Luna described to keep stuck kids suggests that they were intentionally kept at a lower level of care than what they needed. Thus, not only was this practice one of poor quality care, it was also reckless as it placed these kids and their direct-care workers at risk.

When I interviewed Alex, he was upfront about the stuck kids problem. As he put it, “we had kids that would stay with us much longer than they needed to because there was no alternative placement. So, what we want to do is provide the foster care, therapeutic group-homes, outpatient services...(pause), so, when a child is ready to move, they're able to move. So, I do think that we've changed our goals a little bit where—you know—initially we wanted four group-homes; really focus on quality of care. Where—now I think—we want the same thing, but we also want opportunities for the kids to show success. When they are ready to move . . . they're not going to shelters or they're not going back home where the problems . . . originated. We want to be able to show growth and then continue to grow.” In his view, ABC was filling a niche as “we want to really satisfy—really have—the continuum of care.” By attempting to fill this niche, Alex was acknowledging that there was a *dis-continuum of care* in the state as these types of services were in short supply.

Indeed, ABC was in the process of branching out to provide additional services that could “satisfy” the *continuum of care* that was presently nonexistent in the state. Further, while ABC did have stuck kids, this wasn’t entirely due to shadiness on the part of the company. As reported by Gary, there are “other agencies that don’t do their job . . . I hate to say it that way, but again the kid has got to have some place else to go and if they can’t go home, then where are they going to go? That is not ABC’s . . . problem, it is actually the paying agency . . . and I don’t know whether they intentionally drag their feet or whether they are so overloaded with casework they can’t get to it, but whichever way that it is, it doesn’t happen fast enough and we are the ones that have to pick up that slack.” Similarly, Luna reported “[y]ou’ve got one boy over there that’s been there for—going on—probably three years now and granted, maybe that there is because of the political wheels go[ing] . . . slow.” Further, Luna reported that there were “at least nine” kids she could think of that “should have either been put to a higher level of care . . . [to] get help or stepped down into their house, but because of case managers conflicting with that family, or therapists conflicting with that family, it always left that boy stuck in the middle of a tug of war.” While Luna acknowledged that the stuck kids phenomenon was real and that kids weren’t always kept because of the profit motive at ABC, she nevertheless reported that “I’m still gonna say ninety-five percent of the time it was about a profit margin for the company.”

Although ABC did not create the stuck kids phenomenon, it appears to have capitalized on it. Based on what was shared with me, ABC may have dragged its feet in placing kids who needed a higher level of care. In particular, when Luna was told to keep kids whom she believed needed a higher level of intervention than we could provide, not only did this stink of slumcare, but it also put those kids and the staff who couldn’t meet their needs at risk. However, it would be overly simplistic to pin this slumcare practice on ABC alone since the state created the stuck

kids problem. After all, ABC was trying to fill a niche in the dis-continuum of care that existed in the state. If the state had a sufficient supply of alternative placements for these kids, ABC would not have been able to capitalize on bureaucratic delays. Indeed, it would have seemed odd if ABC was dragging its feet when suitable placements were available. More importantly, however, ABC was a subcontractor of the state and was given the authority to provide therapeutic juvenile crime control while attempting to balance quality care with the pursuit of profit. In other words, the state created the conditions under which ABC would be tempted keep kids longer than necessary and capitalize on the stuck kids problem. Although appropriate checks and balances could have assured that the therapeutic side of ABC stayed its course, it was the state that ultimately gave Alex the space to pull the strings in his favor.

#### The Fail-state

Like many states in the US, this anonymous state has turned to the private sector to deliver Medicaid behavioral healthcare services in the name of cost-efficiency. In response, individuals like Alex have heeded the call and formed corporations within the third sector of juvenile crime control that attempt to balance the pursuit of profit with the provision of quality interventions under cost-controlling conditions. Ironically, when states—such as this one—utilize Medicaid managed-care systems and refuse to invest in sufficient in-home and community-based services, they increase the costs of care when kids get stuck in expensive out-of-home placements like Mountain View. While companies like ABC have an incentive to capitalize on the stuck kids problem, it is a problem that originates from the state. Thus, not only is this state failing to provide the most appropriate interventions, it is also failing to provide the most cost-efficient interventions. This double failure is indicative of the fail-state: a form of governing that repeatedly fails to achieve its mandate.

While states like Massachusetts have begun instituting reforms to rectify their stuck kids problem, states like Arizona continue to fall short. However, Arizona is not alone as child advocates across the country have sought to rectify the persistent failures of their states to provide EPSDT services (Luke, 2009; Mello, 2002; Scaparotti, 2007). But, Massachusetts is also not alone, as other states have begun to implement meaningful reforms in their managed care systems. Thus, neoliberalism is not the common denominator as states are figuring out how to balance cost-control and profit with the provision of quality services within their managed care systems. Further, the stuck kids problem is clearly not due to the triumph of managerialism. In fact, it is a problem of mismanagement as it is extremely cost-prohibitive for the state and its managed care entities. Indeed, something other than a managerial ethos is driving the stuck kids problem within privatized public healthcare.

Although an ethos of care has emerged in small pockets of the country, the overall lack of care throughout the nation is what is most glaring, if not blinding. While states have been sued across this country for their repeated failures, it is as if no one has noticed. Although these states are mandated to provide quality care, it is as if no one cares that they continue to fail. Indeed, the silence surrounding these failures is indicative of a much larger social failing as the country as a whole appears to prioritize short-term savings in the form of tax dollars over long-term investments in healthy kids.

Ironically, even though the state has turned to private enterprises such as ABC in the name of cost-efficiency, ABC was *not* cost-efficient. As revealed by Luna and Daisy, ABC's upper management pressured them to keep the beds full at Mountain View. While filling beds may have helped fill the pockets of ABC's owners with Medicaid dollars, it was monumentally cost-prohibitive for the state: especially when kids were ready to go home. More importantly, the

practice of keeping kids was not a stuck kids problem. This was an altogether different animal. This was a profiteering off of poor kids' problems that also happened to be extremely unethical. It was a problem of slumcare. However, because the slumcare practice of keeping kids was antithetical to cost-efficiency, it was also a colossal failure of the state. Ultimately, when subcontractors of the state—such as ABC—are enabled to extend their reach far beyond the communities they are located in and to keep kids in their facilities even when they are ready to go home, they are not only engaging in cost-prohibitive slumcare, they are also failing to fulfill the state's mandate of balancing cost-control with quality interventions. Like the stuck kids problem, this is not due to the magical workings of cost-efficient market forces. It is due to a form of governing that fails to achieve its mandate. It is due to the fail-state.

Indeed, although the state was mandated to provide quality care at a low cost, it failed on both fronts when it enabled ABC to engage in these slumcare practices. Although ABC could be an isolated case of slumcare, the processes that allowed it to persist flowed to and from the state. Further, because these processes are quite ubiquitous, the conditions are not only ripe for *slumcare* to crop up across the country, it already appears to have seeded itself throughout the nation as evidenced by the proliferation of lawsuits. In fact, the details of these cases suggest that poor quality care appears to be the norm rather than the exception. Sadly, the slumcare practices associated with filling beds at Mountain View were not only indicative of poor quality care, they were also indicative of larger processes occurring throughout the US. As revealed in the experiences of my colleagues, the processes that permitted slumcare to take hold were the *subduction of care*, a *paper-trail of propriety*, and the *evasion of criticism*. Together, these three processes account for how the fail-state enabled substandard care to persist at Mountain View.

The Subduction of Care



As I combed through the interviews with my colleagues, it was evident that they were describing an experience that had yet to be captured in either the sociological, psychological or criminological literature. In essence, what they kept describing over and over again was a process whereby the prioritization of care had been overridden by another priority. In an attempt to capture this experience, I scoured the literature and compared preexisting theories, concepts, and terms to what was shared with me. After multiple iterations of comparing these experiences to what I could find, I finally came across a term that *fit*. That term was subduction (see Glaser 1978).

In geological terms, the area where one tectonic plate collides into another is known as a subduction zone. Subduction is the geological process whereby one tectonic plate becomes overridden by the other. Here, I borrow the term to capture the social service process whereby the prioritization of care becomes overridden by another priority when they collide. While the term subversion comes close to describing the experience, it would suggest that care was destroyed or overthrown as opposed to simply being overridden. Indeed, the *subduction of care* does not involve either the elimination of care or even the superseding of care; it is process of de-prioritization: of placing care beneath another priority.

For instance, ABC's decision to extend its reach into Indian Country involved a degree of care as Luna indicated that these services were needed. However, the decision to place reservation kids 100 miles from home involved the subduction of care as Alex placed concerns of expansion above concerns of providing family focused care. To be clear, family focused care was not eliminated or destroyed, as reservation kids had access to family therapy, family visits and home passes. However, the prioritization of expansion meant that families living on Native lands would face monetary and transportation obstacles to these services that non-Native families

wouldn't have to face. Thus, when the logic of the market collided with the logic of care at ABC, care was subducted: it was overridden and de-prioritized. For Native American kids from the reservations, family focused care was placed beneath another priority.

Similarly, the practice of keeping kids also involved the subduction of care as kids were kept from their families longer than necessary. However, as indicated by Daisy, this slumcare practice was not due to blind profiteering. Kids were not kept for the sake of profit as much as they were kept for the sake of the company's survival. As Daisy told her story, she made it clear that upper management wanted her to keep Johnny until another referral came in. In other words, the practice of keeping kids at Mountain View wasn't about keeping them as long as possible. It was about keeping them until their beds could be filled by a new referral so the company could remain viable. If the company were only interested in profit, it would have treated referrals as additional sources of revenue and it would have pressured Daisy to keep the Johnnies of the world even when new referrals came in so that it could fill up additional homes. However, as described by Daisy, if ABC had a sufficient stream of referrals, Johnny wouldn't have been kept longer than needed. Thus, while concerns with sufficient profit flow clearly subducted care in these cases, it wasn't due to the absence of care as much as it was due to concerns of keeping the company afloat being prioritized above quality care. When kids were kept at Mountain View, quality care was being overridden by the prioritization of company survival as opposed to a ruthless pillaging of poor kids.

Indeed, when I asked Daisy if ABC was making a profit, she reported "there are times when we have made profit and it's been a good thing, but I haven't heard a lot about it recently, so I'm under the assumption that it hasn't... I don't think they have." Further, Daisy revealed that ABC was in the process of "closing one of the sites." Thus, not only was ABC operating

with low profit margins—as revealed by Alex—but it also appears to have been struggling to survive. Hence, it would appear that the logic of the market—which prioritizes growth and expansion—overrode the logic of care at ABC as the company grew beyond its capacity to provide quality care. By outgrowing the supply of youth in need of their services, ABC put itself in the precarious position of either putting the company’s survival at risk by emptying its beds or putting kids at risk by keeping them longer than necessary. However, when the management team explored with Daisy how they could provide Johnny with more services, a degree of care was conjured to balance things out. Nevertheless, the degree of care involved in that decision was clearly overridden by concerns with sufficient profit flow. Although care was not completely subverted by the pursuit of profit, it was subducted.

In fact, Luna indicated that quality care was subducted on a regular basis. When I asked her if the pursuit of profit ever got in the way of helping kids, she replied “every day. It was an everyday thing.” As she explained it, “every manager had a budget . . . [but] it was still about saving that very last penny instead of helping that boy...” In a particular incident, Luna reported that ABC “compromised the welfare of that boy over three hundred dollars.” Although we didn’t discuss the specifics of how this child’s welfare was compromised, Luna indicated that she experienced similar situations “maybe four or five times.” Thus, while Luna experienced penny-pinching on a daily basis, it was clear that she experienced the compromising of children’s welfare less frequently. Again, what this shows is that although care was regularly subducted at Mountain View, it wasn’t completely overthrown. If profit was the only motivating factor at ABC, it would have compromised the welfare of children more than “four or five times.”

Although the logic of the market prioritized expansion, profit and cost-control, the subduction of care was not due to the privatization of public healthcare as much as it was due to

ABC being allowed to grow wild. If this hybrid organization had sufficient checks and balances, ABC would never have grown beyond its capacity to provide quality care. Had ABC remained small, it could have maintained a steady profit flow without having to overextend its reach, having to keep kids longer than necessary and without compromising the welfare of kids over penny-pinching concerns. In other words, hybridization does not have to lead to the subduction of care. Although Alex made the fateful decision to bypass his original plan of keeping the company small and grew it to an unsustainable size, he was given the freedom to do so by the state.

While it would be easy to demonize ABC and its CEO for prioritizing growth over quality care, this company was a sub-contractor of the state. Although Alex was portrayed by his management team as a “puppet-master” and as someone who “only thought about money,” the authority he was granted to develop and grow his company was given to him by the state’s Medicaid managed care system which was mandated to balance cost-control with the provision of quality care. While ABC was subjected to some oversight, the company was largely granted ungoverned authority to ensure that quality of care was being balanced with the pursuit of profit.

On paper, ABC was structured so that quality of care decisions could be balanced with profit, but there was virtually no oversight to ensure that quality care was consistently being provided and wasn’t being overridden by the pursuit of profit. Ultimately, ABC made its decision to use Luna’s contacts and expand into Indian Country without obstruction from the state. It also made the decision to expand from one group-home to six within seven and half years without a peep from the state. While ABC ultimately outgrew its ability to provide quality care, it was enabled to grow wild by the state. Thus, the conditions that led to the subduction of care at ABC were enabled by the subduction of care that occurred at the state when it—like so

many other states across the country—prioritized budgetary cost-control over meaningful oversight of quality care.

In regards to the stuck kids problem, once again we are seeing the subduction of care, but in this case it is emanating directly from the state. At Mountain View, some of the kids were *stuck* because more appropriate placements were simply not available. However, the failure of the state to invest fully in a continuum of care is not due to the absence of care or its destruction. It is due to concerns with quality care being placed beneath concerns with budgetary costs. It is the de-prioritization of care—the subduction of care—that explains the stuck kids problem.

Indeed, my colleagues experienced the subduction of care flowing from the larger society as well as the state. According to Dylan, “if you ask me, I’d say it’s just not a priority of the public.” He explained, “most people will think ‘we have social services, they fix all the bad kids,’ and that’s just a problem solved by the money we put into this budget.” According to David, “we have too many broken kids and we don’t have enough support for them. We don’t have enough people willing to put out the time and energy for it.” When Krystal described why she liked her job, she explained it as “working with people that society kind of turns their back to.” Although Dylan, David and Krystal were at the frontlines of Medicaid behavioral healthcare, they experienced the larger society that funded their work as one that placed care for these children beneath other priorities.

While tracing the subduction of care throughout the state and society is beyond the scope of this study, it is consequential that my participants experienced it as a process that flowed from these larger structural sources. Although Dylan, David and Krystal experienced society as prioritizing other concerns, the work they did was dependent on the degree of concern that did exist: albeit insufficient. Further, despite the state’s attempt to build a better mousetrap with

privatized public healthcare, Don lamented “well, you have to remember that they’re going through a state system and how inefficient that is.” Although my colleagues were at the frontlines of Medicaid managed care, they experienced neither efficiency nor quality care. Instead, they experienced the subduction of care when state-level and societal-level concerns with budgetary cost-control collided with the provision of quality care.

#### The Paper-trail of Propriety

While my colleagues experienced the subduction of care flowing from the state and the larger society and reverberating in the slumcare practices at ABC, that doesn’t fully explain how slumcare persists. In theory, the subduction of care can be recognized and rectified with the *emergence of care*. However, there were two additional processes circulating to and from the state that stymied the emergence of care and enabled slumcare to thrive: a *paper-trail of propriety* and the *evasion of criticism*.

During my time at ABC, the state’s Medicaid managed care entity did conduct an audit. The majority of that audit was focused on examining the paper-trail ABC produced. Despite the everyday experiences of slumcare at Mountain View, we passed that audit with flying colors. Thus, not only did ABC have a paper-trail of propriety that hid its slumcare practices from these auditors, but the state also had a paper-trail of propriety that demonstrated its due diligence in ensuring sufficient oversight. How did this occur?

To hide the slumcare practice of keeping kids, ABC merely needed to create a paper-trail that justified keeping them in their group-homes. As Daisy revealed, when she realized she “had to keep them here for a while,” she facilitated it by working on “new skills” and doing “more family therapy.” In other words, Daisy helped create a paper-trail of propriety that justified

keeping kids like Johnny in the group-home so he could work on the “skills” and receive the “family therapy” he needed—on paper.

Tragically, the state’s reliance on cost-effective *paper surveillance* and *statistical surveillance* not only enables a paper-trail of propriety to be produced, but it also helps to justify the state’s actions as the Johnnies of the world are converted from commodities into recipients of needed—as opposed to unneeded—services. Indeed, they become markers of improved access to those services.

Even though ABC violated its own standards of quality care when it overextended its reach into Indian Country, Luna reported that ABC secured contracts with both the Eagle Tribe and the Bear Tribe. Thus, ABC could point to those contracts as a paper-trail of propriety justifying its expansion into those areas of need. Moreover, ABC could simply blame Native American families for not taking advantage of the family focused services they provided on paper. Although Mountain View was 100 miles away from many of the Native families they served—making it virtually impossible for many of these impoverished families to conduct family visits and participate in family therapy—ABC could point to its documents which demonstrate that family focused services were offered. Moreover, if families could not make the trip to participate in family therapy, the therapist can simply note in her paperwork that the family refused to participate.

Despite overextending its reach and compromising family focused care, ABC and the state could also point to the statistics that showed improved access for an underserved population. Tragically, the numbers demonstrating access to needed services enabled slumcare practices to slip through the cracks of paper surveillance as kids were placed further than necessary from their families and kept longer than needed at Mountain View.

Although ABC did not create the stuck kids problem, there was a paper-trail that circulated to and from the state enabling places like Mountain View to capitalize on it. To keep these kids, all ABC had to do was show that it made an effort to search for alternative placements, but couldn't find any. Although the stuck kids phenomenon is cost-prohibitive, the state can point to its budget and proclaim that it simply can't afford to invest in sufficient in-home and community-based services. Thus, while kids linger in inappropriate and expensive settings in states such as this, a paper-trail of propriety flowing to and from the state justifies perpetual inaction.

While child advocates have compiled a *paper-trail of impropriety* in a number of states—including this one—these advocates have often been frustrated with stalling, delays and inaction. For example, in Arizona and Massachusetts, a slew of court documents demonstrated that both of these states were failing to provide kids with appropriate services. Further, in both of these states, groundbreaking settlements were reached that detailed—on paper—how they were going to rectify the problem. Yet, Arizona continues to delay its reforms while Massachusetts is making headway. Tragically, even when a paper-trail of impropriety makes its way to a federal judge and that judge rules in favor of child advocates, slumcare practices will only be rectified when there is also an emergence of care at the state level. Due to the sanctity of state sovereignty, judges defer to the remedial plans of the states. When the emergence of care that motivated the lawsuit doesn't lead to the emergence of care at the state or societal level, groundbreaking settlements become just another layer of paper that enables slumcare to continue. In states like Arizona, a paper-trail of impropriety is easily converted into a paper-trail of propriety as these states point to their budgetary and administrative constraints in implementing the reforms agreed to in their



settlements. Because judges cannot force states to change their ways, meaningful change will only occur when there is an emergence of care at the state or societal level.

### The Evasion of Criticism

Working hand-in-hand with the paper-trail of propriety, is the evasion of criticism. While Daisy attempted to callout the practice of keeping kids as unethical, her colleagues evaded this critique by reminding Daisy that the company needed beds to be filled in order to survive and that “people’s jobs depend on this.” In this regard, the logic of the market was used to override the logic of care and evade the claim of unethical behavior. By appealing to the logic of the market, Daisy was “reminded” that emptying beds would hurt the business, lead to the closing of group-homes and end the employment of her colleagues. Further, by turning the practice of keeping kids “into a positive thing” and providing more services, ABC was able to evade the criticism that they were keeping kids longer than necessary. In this manner, a paper-trail of propriety facilitates the evasion of criticism.

Further, although ABC was structured so that the business side would be counterbalanced by the therapeutic side, Tina reported “we don’t hold everybody accountable.” For example, Tina indicated “I’ve seen the clinical director stand up and say these things aren’t right, they need to be addressed . . . this needs to change, you need to get on this.” What she heard in response was ““oh sure, it’s no problem’ and that falls off on the other side.” Moreover, Tina reported “from my experience, I have to say that when something has been identified . . . [and] has been tried to be addressed . . . that side is muffled by the other side. Imagine a match getting snuffed out.” Thus, while the therapeutic side of ABC has made attempts to voice critiques about the quality of care within the company, the business side evaded those critiques by failing to address problems that have been identified and by muffling those critiques. In addition, when Tina described ABC

as a “snaky business” and portrayed Alex as a CEO who was “in it just for the money,” she added that “it’s a constant ‘I’m going to cover my butt’ . . . It’s just a façade.” Indeed, although “snaky” practices were occurring at ABC, those practices weren’t seeing the light of day as internal critiques were ignored, muffled and hidden in a paper-trail of propriety. Although criticisms were raised, they were routinely evaded.

While the state may be unaware that facilities such as Mountain View are engaging in slumcare practices, it enables the evasion of criticism by failing to conduct sufficient surveillance of actual practices and by failing to capture the lived experiences of practitioners. For example, Daisy, Luna, Dylan, and Lance all shared experiences of ABC keeping kids when it wasn’t necessary, yet the state failed to capture these experiences with its method of oversight. Indeed, by relying on paper surveillance and statistical surveillance and ignoring the lived experiences of practitioners, the state—wittingly or not—evaded criticism by failing to detect its very existence. By failing to interrogate what the numbers produced by ABC *meant* to the people on the ground, the state enabled experiences of slumcare to remain hidden. For example, numbers that show the provision of needed services fail to convey how practitioners feel about keeping kids in inappropriate settings. Numbers showing improved access to an underserved population fail to convey how family focused care was compromised for Native families. Moreover, numbers that show successful discharges fail to capture how often discharge was unnecessarily delayed

Although child advocates in this state—like many others—have raised critiques about the services being provided to children, court documents around the country show that states generally attempt to evade those critiques rather than simply accepting them. In Arizona, for example, the state attempted to evade criticism by claiming in 1993 that it should not be held responsible for the actions of its subcontractors (*J.K. v. Dillenberg*, 1993). Further, when

Arizona finally agreed to settle the case in 2001, the settlement agreement made it clear that Arizona was not admitting liability (J.K. v. Eden, 2001). After the settlement, the child advocates argued that “seven years later, the state still had not complied with the terms of the agreement” (ACLPI J.K. v. Humble, n.d.). When the child advocates filed a motion to enforce the agreement in 2009, Arizona attempted to evade criticism once again by moving to terminate the court’s jurisdiction. Although the Ninth Circuit Court of Appeals denied Arizona’s motion in 2012, the parties were sent back to the negotiating table to come up with a remedy. The latest update provided on the website of the child advocates indicated that despite the victories in court and despite the settlement agreement, “Arizona has repeatedly failed to meet its federal obligations” (ACLPI J.K. v. Humble, n.d.).

Surprisingly, I discovered that in 2014, the “22+ year JK v. Humble lawsuit” was dismissed at the request of the plaintiffs according to the ADHS director’s blog (Case Dismissed: Jason K v. Humble, n.d). The one paragraph order granting the motion to dismiss—posted on the ADHS website—states that the case was being dismissed after a finding of “good cause” (J.K. v. Humble, 2014). The basis for the “good cause” finding was not mentioned.

On July 21, 2015, I placed a call to Anne Ronan, the lead attorney for the plaintiffs. When I asked her about the dismissal, she reported that the special master, who was appointed to oversee the case, had significantly “narrowed” the obligations of the defendants in the settlement agreement. As she put it, major components of the 2001 settlement agreement were “read out of the settlement” because they were interpreted as not establishing clear contractual obligations. The “only thing” that was interpreted as establishing an obligation was the requirement to improve their quality management system. When I asked Anne if the defendants improved their quality management system, she reported “they never did that.” Although a quality management

system was in place, she indicated that the information they collect “isn’t used for anything.” Although a report is published based on the information that is collected, “they never do anything with the information from the report.” When I asked her if she and the clients she represented believed that the defendants had fully satisfied the obligations laid out in the original settlement agreement, she responded “no.”

Although Anne described the decision to withdraw the motion for noncompliance as a “difficult” one, she didn’t want to take the risk of a “negative judgment” that could establish a negative precedent in the law. Nevertheless, Anne reported that the litigation “did make a difference.” In the four years that followed the original settlement, she indicated there was “a lot of change” that occurred because the leadership at the time “cared.” In her experience, to ensure quality “leadership has to care about quality.” Although she “could never get them” to implement an “on-going assessment” to identify “service gaps,” those leaders did “build a structure” for a number of needed services. However, after those first four years, the momentum changed with “new leadership” and things went “down hill.” Presently, Anne told me that providers in Arizona are “not required” to offer evidence-based services, although some do. In addition, while some providers offer evidence-based practices “in theory,” sometimes it is “not the quality you would expect.” Although some providers do institute “quality training,” it is “up to the providers.” Based on her experience with this case, Anne stated “there is only so much a lawsuit can do.” Ultimately, “you got to have a community that demands quality care.”

For over 22 years, Arizona has evaded criticism that it is failing to ensure that impoverished children are receiving quality Medicaid behavioral healthcare services through its managed care system. While it is unknown if the state is infested with slumcare institutions, the conditions are ripe for slumcare to take root. Based on what was shared with me, the subduction

of care is occurring at the state level as Arizona has placed other priorities above ensuring quality care, it has crafted a paper-trail of propriety by creating a quality management system and producing reports that are reportedly never used for anything, and it has successfully engaged in the evasion of criticism as the lawsuit was finally dropped when contractual logic was used to gut the original settlement agreement.

However, this story is not all doom and gloom. Based on the evidence collected here, a fail-state can correct itself with the emergence of care. In Arizona, the emergence of care among child advocates did produce a paper-trail of impropriety that was heard by the courts and an implied acceptance of criticism took place as Arizona instituted major changes in the first four years following the settlement. Indeed, based on what Anne reported, the lawsuit helped facilitate the emergence of care at the state level. While the momentum may have been lost, it is possible that it can reemerge: especially if a culture of care arises and the community “demands quality care.”

Although it is my sincere hope that ABC is an isolated case of slumcare, it is highly unlikely. The processes that enabled it to exist and thrive flowed to and from this state. Unfortunately, those very same processes are on display throughout much of the country as states, Medicaid managed-care entities and their private contractors place concerns with budgetary cost-control and profit above quality interventions and meaningful oversight. This systemic subduction of care is widespread and although it has spurred the emergence of care in a number of lawsuits around the country, the typical response by the states is to engage in a prolonged evasion of criticism. Even when plaintiffs win in court and receive groundbreaking settlement agreements, those agreements can become yet another paper-trail of propriety that facilitates further evasion and continued subduction of care. Although the emergence of care in

places like Massachusetts and Connecticut provide a glimmer of hope, slumcare will continue to hide in the shadow of the fail-state whenever and wherever it takes hold.

### Conclusion

The rise of the neoliberal state has garnered a lot of attention in academia and has been associated with the emergence of the third sector of juvenile crime control (Garland, 2001). Although the impetus behind neoliberalism can be found in the faith our society has placed in the workings of the market and its managerial ethos, this study of Medicaid managed care reveals that the third sector of juvenile crime control is riddled with mismanagement. Despite the mandate to balance cost-control with quality interventions, state administrators around the country have been sued by child advocates because the managed care entities they oversee have repeatedly failed to provide kids with quality services. In addition, these lawsuits have revealed that the failure to provide adequate in-home and community based services have contributed to a stuck kids problem that is cost-prohibitive. In other words, these states have failed to achieve their neoliberal mandates. In fact, this study demonstrates that, not only is neoliberalism porous enough to permit mismanagement within the third sector, but it is also flexible enough to allow the emergence of care to take hold as states like Massachusetts and Connecticut have begun to institute reforms within their managed care systems. Indeed, slumcare is not the necessary result of neoliberalism nor is it due to the triumph of market forces. It is a product of the fail-state. It is the subduction of care that enables hybrid institutions like ABC to become unbalanced.

While a culture of control may have embraced the managerial ethos of neoliberalism and its promise to manage our most troubling social problems, the hybrid institutions that arose within the third sector of juvenile crime control have often brought with them a culture of care as they promise to balance cost-control with quality care. Unfortunately, when the managerial ethos

of the market collides with the ethos of care, it can lead to the subduction of care when sufficient checks and balances aren't put into place. Indeed, this occurred at Mountain View as ABC overextended its market, kept kids longer than necessary and capitalized on the stuck kids problem. However, when a culture of care is maintained at the provider, contractor, and state level, institutions like ABC can be prevented from growing wild and engaging in slumcare practices. In fact, the pursuit of profit can be balanced with the provision of quality care, but this would require sufficient checks and balances.

Indeed, although ABC had a built-in incentive to fill its beds, it could have done so without sacrificing quality care. Had a culture of care taken hold at ABC and kept the business side in check, it could have established group-homes in Indian Country and kept the growth of the company to a sustainable size. Although ABC's CEO reportedly engaged in a number of "snaky" practices, his decisions were ultimately enabled by a state that failed to engage in meaningful oversight to keep him in check.

## Conclusion

In this study of behavioral health practitioners' experiences, I have been haunted by the stories that were shared with me. While I may never be able to exorcise the torment that motivated this project, it is my hope that the specter of slumcare and the fail-state can be brought to light. Indeed, I hope that a reckoning will come for multiple forms of service corruption as the processes that link them together are exposed.

Like many stories, this one began with a bright-eyed individual and a dream. While Alex may have been spinning a tale, I found myself captivated by his drive to balance the pursuit of profit with the provision of quality care. In telling moments, not only did Alex reveal that slumcare was a part of the field he was trying to change, he also admitted that it permeated his own company. Despite his best efforts to provide high quality care, Alex was riddled with a constant supply of weak staff who facilitated chaos. Although Alex was able to achieve high quality ratios, the industry trends he competed with dictated a pay rate that made it impossible to retain quality direct-care workers. In addition, Alex sheepishly acknowledged his ignorance of Native American diversity as he attempted to serve reservation communities. Disturbingly, he also admitted that restraints were overused in his company and that collusion occurred under his watch. While it would be easy to vilify the pursuit of profit at ABC, the findings from this study



suggest that something much more subtle—and, in many ways, more basic—was at the heart of slumcare.

Whether it was cost-control, behavioral correction, power-maintenance, or the pursuit of profit, what enabled each of these priorities to run amok was the de-prioritization of care by the state. Although the slumcare practices associated with filling beds were closely aligned with the pursuit of profit, it was the placing of care beneath the pursuit of profit that led to those practices. Indeed, what linked organized chaos, the therapeutic void, systemic endangerment, and filling beds together was not the pursuit of profit, but the de-prioritization of care by the state. Further, by allowing ABC to account for its own actions, the fail-state enabled the company to evade criticism that it was providing substandard care to the poor and the vulnerable.

In the course of conducting my interviews, it became clear that Alex—the CEO—was not a saint. However, it was also clear that he was operating within a structure that enabled some courses of action while constraining others. Indeed, the set of priorities he was mandated to balance were already rigged to de-emphasize quality care.

Nevertheless, slumcare is a tale of both structure and agency. In terms of structure, the state was mandated to balance quality care with other priorities when it agreed to participate in Medicaid. However, the fail-state enabled slumcare when it placed quality care beneath other priorities such as cost-control and behavioral correction. That is, slumcare practices were enabled by the subduction of care.

In practice, slumcare should inspire reform when it is discovered. Indeed, many of my colleagues attempted to prevent and rectify slumcare through transformative agency. Unfortunately, the fail-state permitted slumcare to persist through two additional processes: the paper-trail of propriety and the evasion of criticism. In this manner, counterfeit therapists—such

as Daisy—are enabled to provide slumcare in spite of attempts by their colleagues to transform their practices.

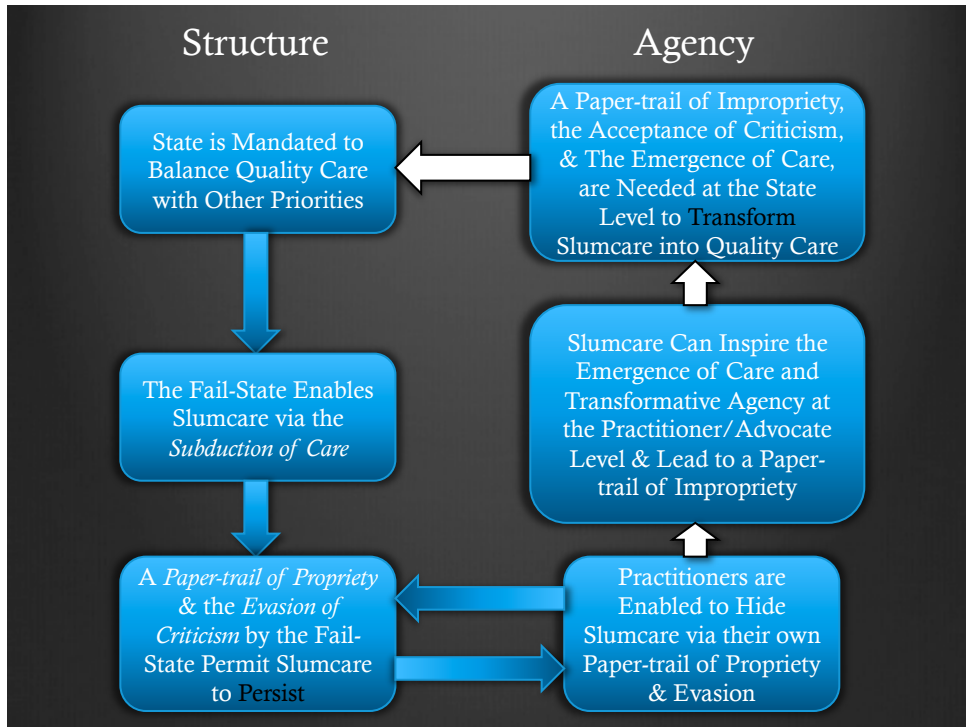
As a cyclical process, the paper-trail of propriety begins with the state. This process is put into motion when the state produces and/or invokes a paper-trail to sanction the means by which it balances its priorities. Agents of the state contribute to this process when they are enabled by the state to produce a paper-trail showing that they balanced those priorities in practice. When the state conducts its audits and primarily relies on reviewing the paper-trail produced by its agents, it completes the process and closes the loop. This paper-trail not only justifies the actions of the state, but it also enables its agents—such as ABC—to justify their actions; especially when actual surveillance of their practices are limited or non-existent. In this manner, paperwork validates paperwork while experiences of awful, dreadful and dangerous practices are hidden between the numbers of effectiveness and between the lines of clinical notes.

The evasion of criticism then works hand-in-hand with the paper-trail of propriety. When agents of the state are enabled to produce their own paper-trail, they can evade critique that they are providing slumcare through the production of statistical illusions and fraudulent paperwork. By enabling its agents to cover up slumcare practices in their paper-trail, the fail-state also evades critique. Together, the subduction of care, the paper-trail of propriety and the evasion of criticism enable slumcare practices to persist (see Figure 1).

In terms of agency, there is a negative side to agency and a positive side. On the negative side, practitioners are permitted to hide slumcare practices when the fail-state enables them to produce their own paper-trail of propriety and to evade criticism. On the positive side, slumcare can inspire the emergence of care and lead to transformative agency. When practitioners, clients and advocates use their agency in efforts to transform slumcare into quality care, it can lead to a

paper-trail of impropriety. However, even if a paper-trail of impropriety reaches state actors, it would need to be joined by the acceptance of criticism and the emergence of care at the state level to transform slumcare into quality care.

Figure 1



Although this fail-state repeatedly fails to achieve its mandate, it will continue to fail until these processes are reversed. That is, slumcare will only cease when there is an *emergence of care*, a *paper-trail of impropriety* and the *acceptance of criticism* at the state level; i.e., at the structural level. While the emergence of care and transformative agency at the practitioner and advocate level can inspire awareness of slumcare and soften its impact, they cannot change the structures that enable it on their own. Without the emergence of care and the acceptance of criticism at the state level, a paper-trail of impropriety will either be ignored, denied or used to

create settlement agreements that simply become part of a new paper-trail of propriety that enables slumcare to continue.

### The Emergence of Care

The need for care to emerge at places like Mountain View is dire. However, this need implicates more than just ABC and this particular fail-state. Indeed, it implicates our society as a whole and the degree of care we place on ensuring that poor and vulnerable youth are appropriately taken care of in our institutions. Although many of us may not be aware that slumcare exists, a paper-trail of impropriety—linking a number of states to substandard care—can easily be amassed if you know where to look. In fact, the scariest part of this story is that the processes that enabled slumcare to persist at Mountain View are evident across the US. In lawsuits around the country, advocates have been claiming for years that substandard care is rampant among Medicaid managed-care systems (Luke, 2009; Mello, 2002; Scaparotti, 2007). Yet, no one seems to notice.

While there is some indication that the emergence of care that motivated these lawsuits has led a few states to make reforms, the typical response is for states to evade criticism. That is, they usually deny responsibility for the allegations made in court or they argue that the care they provided was sufficient (see *J.K. v. Dillenberg*, 1993; *Rosie D. v. Romney*, 2006; Scaparotti, 2007; Weithorn, 2005). When settlement agreements are reached and states promise to make significant changes, they often fail to live up to those agreements (see Bird, 2005; Scaparotti, 2007). Tragically, these lawsuits become just another means of producing a paper-trail of propriety as lofty reforms are put in writing and slumcare continues. Although these agreements are often made without the means or the will to see them through, these fail-states continue to evade criticism through legal briefs and periodic reports. Indeed, it is common for advocates to

feel unsatisfied with the capacity of lawsuits to make significant change (Scaparotti, 2007).

Although the emergence of care among advocates is often necessary for the state to become aware of slumcare, it is insufficient to create meaningful reforms.

In order for the state to place quality care on an equal footing with other priorities—such as cost-control—a sense of urgency must be felt at the state level. If we want to foster quality care in our child-serving institutions, the emergence of care has to take hold in our state capitals. However, this would not only require a paper-trail of impropriety that details how slumcare slips through contemporary means of oversight, it would also require the acceptance of criticism by the state.

Indeed, the need for care to emerge at the state level was evident at Mountain View. For example, during my interview with Alex, it was clear that he was still motivated to provide higher quality care than what he experienced with his former employer. Like many of our colleagues, he envisioned how interventions could consider the broader context of these kids' lives.<sup>70</sup> As he put it, "I think family is vital. You know, a lot of times we're serving the family unit, not the child." In fact, Alex indicated "I would see the therapist interacting with family as being probably more important than focusing on the child." He would explain:

I think a lot of it has to do with their parents. So, I think that that's what really needs to

be addressed, more so than pulling the kid out of the home. You know, we run group-

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<sup>70</sup> According to Don, "we have to have a parent-child intervention and we don't have it here... I think that [with] any behavioral problems, the parents should be involved." In Krystal's experience, "what we do in the group-home doesn't mean that they're going to be okay when they leave. The family needs to be in tune with what's going on... Because, otherwise it's just a disconnection..." When Luna lamented how ABC sends kids back into "dysfunctional" families, she discerned "whatever that dysfunctionality was or continues to be, that needs to be fixed..." Further, she proposed that "a therapeutic alliance with both family and child should have been the optimal goal to begin with."

homes, so I do think there's a need for group-homes, but I would say (pause); I would say a good thirty percent of our kids don't need this level of care. If they had appropriate in-home services where we send a therapist, a direct-care professional out to the home to work with the family, I think that would be more appropriate than pulling the kid out and putting him in a group home.

In fact, Alex has acted on this emergent ideal of care and offered in-home services.

Although ABC has “sent staff back into the home—at our own expense—to help the families deal with the child coming back,” Alex lamented “we need the funding source to pay for it.” Without public funding for this alternative, ABC—as a state contractor—has been hindered from providing what the company believes is the most appropriate intervention. That is, Alex was constrained from pursuing his ideals of quality care. As he put it, “it is not an issue that ABC can resolve by itself.”

In Alex's experience, the emergence of care had hit a ceiling. While Alex was beginning to see the child's family environment as an important site of intervention, he was still operating under a system where “we bill according to the diagnosis. We have to create treatments, treatment plans, based on the diagnosis.” He would explain further:

So, I think a lot of times, a lot gets lost. You're looking at (pause)—you know—(pause); the kids become their diagnosis. The kid's ADHD so we treat the ADHD. We don't treat Johnny. When a lot of times, I think you need to focus more on Johnny and just the dynamics of his life—you know—the family unit, what he's gone through; although all that stuff isn't necessarily identified. I think, a lot of times when a kid misbehaves—you know—you hear it all the time: ‘well, he needs more meds.’ Well—you know—that's great. That might give the staff some respite, but it's really not going to address the issue.

Ironically, Alex came to see the diagnoses the kids had to have in order to receive treatment as an inappropriate focus of intervention. In his experience, “a lot gets lost” when these kids are immediately pathologized (see Conrad & Schneider, 1992). Indeed, this was a common experience at Mountain View. Repeatedly, my participants in this study revealed that—in their experience—the source of behavioral problems resided in the distressed environments these kids came from. In fact, the therapeutic void at Mountain View tormented my colleagues precisely because they came to see the trauma the kids were dealing with in their communities as the key issue that needed to be addressed. While funding for home-based services would be a good place to start, care would have to emerge beyond the grounds of Mountain View before it could happen.

Without question, there is an emergent need for care to arise and take hold at the state-level. However, when we consider the “dynamics” of Native American lives, the need for care is particularly urgent. If ABC and the state were to focus on the “family unit” as suggested by Alex and consider what the Native child has “gone through,” not only would this implicate a definition of family that is much broader than Eurocentric definitions, it would also implicate the collective—intergenerational—trauma these communities are dealing with (see Garrett, et al., 2014). Indeed, if we were to provide these kids with culturally appropriate interventions, we would have to move past the individualized focus of most programs and consider how we can intervene at the community-level (Goodkind, et al., 2012).

Luckily, a number of Native American scholars and advocates have already laid the groundwork for how such interventions could be implemented (see Brave Heart et al., 2012; Garrett, et al., 2014; Goodkind, et al., 2010; Gone, 2013). In fact, Native American communities across the country have begun implementing initiatives “directed at fostering resilience among

Native youth and promoting positive growth and development” (Garrett, et al., 2014, p. 487).

Increasingly, Native American communities have “identified a need for the development of culturally based mental health interventions that build upon traditional healing practices already successful within communities, and which include a recognition of the impacts of past and current oppressive policies and intergenerational trauma” (Goodkind, et al., 2010, p. 859).

Although evidence-based interventions for acute trauma can be adapted for Native American youth, Goodkind et al. (2010) found that positive results from this type of intervention were not sustained after 6 months. The authors suggested that the return to baseline may have been due to the likelihood of “additional violence exposure” in these distressed environments (pp. 869-870). In addition, the authors suggested that the narrow focus of the intervention “might not fully address the complex, chronic traumas that most AI [American Indian] youth in our study were experiencing” (p. 869). Moreover, given the high degree of resistance to participate in the program, the authors indicated that if evidence-based interventions are to be adapted for Native American communities, they may require what is referred to as “deep-structure” adaptations as opposed to the largely “surface-level adaptations” that were used in this study (p. 869). In particular, it was noted that although it is increasingly recognized that many Native American communities are impacted by collective—intergenerational—trauma, this evidence-based intervention failed to address it. Indeed, it has been argued:

[W]e cannot effectively address behavioral health (mental health and substance use) inequities by focusing primarily on individual-level solutions. If social injustice is one of the root causes of distress, healing must be explicitly guided by transformative social change efforts that build on individual, family, and community strengths (Goodkind, et al., 2012, p. 1019).



In other words, it may be time for violence reduction interventions to be infused with the “sociological imagination” (Mills, 1959, p. 7)<sup>71</sup> and recognize the need to make changes at the community, state, and societal-level. That is, “intervention should be directed at the actual cause of problems—not just to ‘fix’ individuals but to change social and economic policies and current distributions of power” (Goodkind, et al., 2012, p. 1022). While healing has to occur at the individual, family, and community level, it has been argued that it must occur “within an ecological framework that recognizes the impact of multiple levels of context . . . on individual development and health” (Goodkind, et al., 2012, p. 1022). Unfortunately, “addressing problems arising from current trauma does nothing to prevent them from reoccurring if it does not change social injustices and underlying conditions” (p. 1032). Whether we want to open our eyes to it or not, there is an emergent need to address the “current social inequities” that affect exposure to trauma and undermine the ability of marginalized communities to address this persistent societal problem (p. 1033). If we are to make the necessary changes, “societal transformation must occur” (p. 1023). In other words, the emergence of care must take place at the state and societal-level if we are to replace slumcare practices with appropriate community-level interventions. While this may sound like a utopian wish, there are indications that the seeds of change are beginning to sprout.

### Time for Change

Over the last few years, our nation appears to have turned a corner in how we think and talk about institutionalized injustices. Although the difference is subtle, centering our thoughts and discussions on places—like Ferguson and Baltimore—instead of individuals—like Michael

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<sup>71</sup> According to Mills (1959), the “sociological imagination . . . is the capacity [of individuals] . . . to grasp what is going on in the world, and to understand what is happening in themselves as minute points of the intersections of biography and history within society” (p. 7).

Brown and Freddie Gray—has marked a significant shift in the conversation. Instead of invoking individuals as the primary locus of recent criminal justice controversies, we have begun to entertain the possibility that entire communities can be caught in the crosshairs of unjust treatment. This rhetorical turn from individuals to places is sorely needed and long overdue.

For well over thirty years, criminologists have rediscovered that place matters when it comes to both criminalization and criminality (Beckett, et al., 2006; Blau & Blau, 1982; Currie, 2013b; Hipp, 2011; Krivo, et al., 2009; Morenoff, et al., 2001; Tonry & Melewski, 2008; Wacquant, 2010). Although the War on Drugs has been a catastrophic failure throughout the country, the devastation it has caused has been borne by very specific locations in the urban landscape (Beckett, et al., 2006; Clear, 2008; Roberts, 2004; Tonry & Melewski, 2008). While mass incarceration has swollen our prisons and jails with non-violent offenders, they have disproportionately been drawn from particular locales. Although violent crimes have dropped throughout the country as a whole, certain neighborhoods remain prone to violence and this violence has been shown to emanate from the heartbreaking conditions of these marginalized spaces (Blau & Blau, 1982; Griffiths, 2013; Jones-Webb & Wall, 2008; McCall, et al, 2010; Sampson, et al., 2005). Moreover, it is well known that the victims of violence are disproportionately caught in the quagmire of our nation's most abandoned and isolated sectors (see Auyero, et al. 2015, Richie, 2012).

Despite the well-established importance of place within criminology and the recognition that government policies facilitated the construction of unequal ecological environments along the lines of race and class (Avila & Rose, 2009; Highsmith, 2009; Massey & Denton, 1993, Pattillo, 2005; Sharkey, 2013), most of our rehabilitative interventions remain myopically focused on individuals; as if rehabilitating offenders one at a time will alter the unjust conditions

that ignite violence (see Blau & Blau, 1982; Griffiths, 2013; Jones-Webb & Wall, 2008; McCall, et al, 2010; Sampson, et al., 2005). As if changing how an individual thinks and behaves will erase the community-level consequences of enduring segregation (see Pattillo, 2005; Sharkey, 2013), isolation from quality schools (see Billings, et al., 2014; Fiel, 2015; Reardon, et al., 2012), persistent housing and employment discrimination (see Pager & Shepherd, 2008), rampant desperation, and intergenerational trauma (Danzer, 2012; Wilkins, et al., 2013; see Sharkey, 2013, Anderson, 1999). Indeed, although the *criminological imagination* (see Young, 2011) has reaffirmed the importance of place—of context—when examining what propels swaths of individuals into violence, the importance of place has yet to fully illuminate the rehabilitative ideal (see Currie, 2013b; O’Connor, 1996). By and large, we still talk about rehabilitating individuals instead of rehabilitating places (see Borum, 2003; Cullen, 2006; Greenwood, 2008; Howell & Lipsey, 2004; Lipsey & Cullen, 2007). The fixation with correcting individuals not only leaves the neighborhood conditions they come from and the policies that created them beyond reproach, it also ignores the degree to which “non-violent” communities have benefitted from selective government investments.

Inexorably, when the unjust enrichment of some was combined with unfair divestment from others, it not only deepened the racial divide in the U.S., it reverberated across multiple generations (see Sharkey, 2013). As a result of our discriminatory housing and urban renewal policies, living in a “non-violent” community became a privilege that was largely rooted in a selectively benevolent state: one that didn’t think twice before investing in an all-too-idyllic and all-too-exclusive dream of white picket fences, access to quality schools, and unencumbered commutes to work. As this privilege has been handed down across generations, it has enabled the accumulation of family wealth (Katz, 1993; Massey & Denton, 1993; Sharkey, 2013; see Young,

1999). On the other side of the ledger, however, those who were deliberately left out of this dream are still struggling with the nightmare these policies created (see Roberts 2004, Sharkey, 2013). While this nightmare mostly manifests in the struggle to survive in these marginalized communities (Anderson, 1999; Contreras, 2013; Jones, 2010; Rios, 2011), it also manifests in disproportionate eruptions of violence (Blau & Blau, 1982; Griffiths, 2013; Jones-Webb & Wall, 2008; McCall, et al, 2010; Sampson, et al., 2005). Although the caldron of concentrated disadvantage is colorblind in its effects on violence,<sup>72</sup> the policies that placed a disproportionate number of racial minorities into this caldron were deliberate. As these places continue to erupt, it is imperative that we begin to imagine how the conditions of these places can be rehabilitated. It is incumbent upon our generation to undo the consequences of unjust enrichment and unfair divestment. If we are to be a fair and just society, these communities deserve the same types of investments we made during the spawning of suburbia. The importance of place and the policies that created unequal neighborhood ecologies should be at the very center of our attention.

However—as policing and mass incarceration face increased scrutiny across the U.S.—the contemporary rehabilitative ideal continues to focus narrowly on individuals instead of places. In fact, it is almost sacrilegious to critique the modern rehabilitative ideal. With aplomb, it is ushered forth as a progressive beacon: a way out of the punitive policies of the past (Cullen, 2006; Greenwood, 2008; Howell & Lipsey, 2004; Lipsey & Cullen, 2007). The mantra of discovering and endorsing *what works* not only promises that crime and violence reduction are possible without having to get tough, but that a failure to support what works is ignorant.

However, it is far from clear that what works is *what works best* (see Farrall & Maruna, 2004;

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<sup>72</sup> While the literature on the Latino paradox suggests that Latinos are less inclined towards violence in these areas (see Ousey & Kubrin, 2009; Stowell, et al., 2009), evidence indicates this may be related to generational factors as opposed to neighborhood factors. In fact, Latinos become more crime-prone the more Americanized they become (see Sampson, 2008b).

Feeley & Simon, 1992; Hannah-Moffat, 2005; Hubbard & Matthews, 2008; Kemshall, 2002; Matthews, 2009; Maurutto, et al., 2006; O'Malley, 2004; Robinson, 2001; Tauri, 2013; Young, 2011). It is far from clear that statistically significant reductions in recidivism (see Drake et al., 2009) translate into meaningful changes in our most disadvantaged communities. It is also far from clear that what is *cost effective* is socially just. Indeed, it is time to recognize that in our rush to endorse what works in the most cost effective manner possible, we have instituted a number of interventions that repeatedly fall short of what works best and what is just.

Increasingly, research finds that trauma and adverse experiences during childhood are implicated in violence (Duke et al., 2010; Finkelhor et al., 2007; Smith et al., 2005; Widom, 1989). Yet, many of the violence reduction programs heralded as exemplars of what works don't address underlying traumas (Cullen, 2006; Greenwood, 2008; Howell & Lipsey, 2004; Lipsey & Cullen, 2007). In addition, a wealth of research has shown that our most isolated and most unjustly treated communities are suffering from intergenerational and community-level traumas that are not amenable to individualized interventions (Brave Heart, et al., 2011; Brave Heart-Jordan, 1995; Evans-Campbell, 2008; Gone, 2009; Gone, 2013; Goodkind et al., 2011; Goodkind, et al., 2012; Wiechelt, et al., 2012; see also Wilkens, et al., 2013, Danzer, 2012). Yet, most trauma-informed interventions are aimed at individuals. While some of the most effective brand name programs consider the importance of the child's ecology (see Henggeler & Schoenwald, 2011), pragmatism and the logic of cost-effectiveness have led many states to implement less expensive generic practices that don't address the child's environment or community (Fagan & Catalano, 2013; Henggeler & Schoenwald, 2011; Lipsey & Howell, 2012; see Welsh & Farrington, 2012). Further, because many of the community-level harms afflicting these places are specific to the racial and ethnic identities of these communities, it is known that many

evidence-based interventions are culturally inappropriate (see Aisenberg, 2008; Bernal, et al., 2009; Briggs & McBeath, 2010; Briggs, et al., 2011; Castro, et al., 2010; Goodkind, et al., 2010; Hodge, et al., 2010; Jackson, 2009; Jackson & Hodge, 2010; Kumpfer, et al. 2002; Miao, et al., 2011). Moreover, when cost-benefit analyses are conducted to determine if rehabilitative interventions are worth the investment, the legacy of unequal investments in communities is erased from the equation (see Drake et al., 2009). In a fair assessment of costs, the legacy of unequal investments and the debits owed our abandoned communities must be included in the ledger (see EagleWoman, 2010). Never mind the fact that the privatization of social services has led to a growing behavioral marketplace that is guided by the pursuit of profit: the social costs of which are largely unknown.<sup>73</sup>

Without question, the move from punishment to treatment is a step in the right direction (see Lipsey, 2009). However, if we are to learn from the past, we should listen to the grassroots leaders within these communities who have repeatedly fought for community-level interventions and exposed the limits of individualized treatment provided by outsiders (Cazenave, 2007; Goodkind, et al., 2011; Markowitz & Rosner, 2000; Naples, 1991). The assumption that individuals in these communities primarily need correction as opposed to equal investments in their lives and equal opportunities is not only hubris, it is a disturbing erasure of past and present inequities within our society (see Farmer, 2004; Goodkind, et al., 2010; Goodkind, et al., 2011). Further, the assumption that communities are not changeable or malleable belies the fact that these communities were dramatically changed as a result of the unequal investments of the not-

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<sup>73</sup> Indeed, the behavioral marketplace has attracted a host of “competitors” who sell cheap versions of *brand name* programs to states looking to save costs (Greenwood, 2008, p. 204). The dangers associated with these *counterfeit* programs are largely unknown.

so-distant past.<sup>74</sup> In addition, there is ample evidence that when we attempted to invest in community-level empowerment during the War on Poverty, community action programs not only helped galvanize community leadership and collective efficacy in some of our toughest inner-city neighborhoods (Cazenave, 2007; Markowitz & Rosner, 2000; Naples 1998), but they also assisted a number of Native American communities in their struggle for self-determination (Castile, 2005; Cobb, 2002; Fletcher & Vicaire, 2012; Miller, 1990). Ironically, some of these programs were so successful at empowering communities they were ultimately shut down when it became clear that the existing power structure didn't like what these communities had to say (see Cazenave, 2007). Tragically, grassroots calls for equitable community investments and equal opportunities encountered so much resistance from local governments and the established social service professions that funding was ultimately cut "before it could do much more than get started" (O'Connor, 2001, p. 172, see Cazenave, 2007; Fletcher, 2012; Young, 2011). Indeed, the positive effects of community action programs are profound given how quickly they were dismantled (see Castile, 2005; Cobb, 2002; Fletcher, 2012).

What if we had championed community empowerment and listened to what these communities had to say instead of stifling their voices? What if we had embraced their proposals

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<sup>74</sup> Although investment in community-level empowerment was attempted briefly via the community action programs of the War on Poverty, those programs encountered resistance from local governments and the established social work profession (O'Connor, 2001, p. 172; see Cazenave, 2007; Fletcher, 2012; Young, 2011,). Grassroots calls for quality education, decent housing, and access to equal opportunities were derided for being too radical and for inciting class warfare (O'Connor, 2001; Young, 2011). The irony, of course, is that our housing and urban renewal policies had already dug the trenches that unjustly aligned opportunity with race and class. Although the community action programs are often dismissed as disruptive failures, they often produced enduring positive effects (see Castile, 2005; Cobb, 2002; Fletcher, 2012). Ironically, not only is there evidence that community action programs worked, but that many of them were shut down quickly because they worked too well.

instead of resisting their efforts to obtain equitable services and equal opportunities? What if reductions in recidivism—the current marker of *gold standard* interventions—were replaced with the goals of community empowerment, providing equitable services, and ensuring equal opportunity? How different things might be if the *criminological imagination* connected what we know about the importance of place to the legacy of unequal investments and the need to level the playing field? Imagine what the rehabilitative ideal would look like if it had fully embraced the empowering logic of people like David R. Hunter—social worker and philanthropist—who said:

There is a danger in the tendency to think that the lasting solutions lie in rehabilitating people or in ‘helping people in trouble.’ The lasting solutions lie in arranging our social and economic institutions and systems so that there are opportunities for all to work, to have adequate income, to participate in social relationships that are not hurtful or destructive, to be a part of a larger society, and in improving the institutions that prepare people to fill these roles (Hunter, 1964, p. 249).

If we can make these connections in our everyday thoughts and everyday conversations, we might finally move beyond what works to *what is just*. If we can acknowledge that investments in suburbia were worth it, we can surely acknowledge that investments in our nation’s ghettos, reservations, and opportunity deserts are long overdue. However, before we can get there, criminologists who are concerned with social justice must raise consciousness of how the modern rehabilitative ideal is largely disconnected from what we know about the importance of place and the legacy of unequal investments. As researchers, we can support and amplify the voices of those who know—through experience—that rehabilitating individuals one-at-a-time isn’t addressing the source of the problem. As scholars, we can help empower and support the



organic emergence of care that is sprouting in marginalized communities across the country. That is, we can support what is just.

### What is Just

If we dare to venture to the margins of our society and listen to what grassroots leaders and social justice activists are saying, we just might be able to move beyond what works in statistical models to what is just according to basic principles of fairness. Our nation's ghettos, reservations, and opportunity deserts didn't ask to be treated unfairly and unjustly throughout history and they certainly aren't asking for a handout. If we are to be a fair and just nation, we need to invest in these communities in the same way we invested in suburbia. These marginalized spaces need to be brought into our networks of opportunity and provided with equitable services. Indeed, it is time that we see this kind of investment as a "social justice issue" (see Bussey & Lucero, 2013, p. 396; Richie, 2011).

Although the concept of collective trauma at the hands of the state has emerged and resonated with Native American communities across the country, it applies to our nation's ghettos as well and it is time to make amends. Indeed, there is a need to recognize that the collective—intergenerational—trauma afflicting our most unjustly treated communities is not amenable to individualized treatment. To do what is just, it is time to listen to the grassroots activists and community leaders who manage to keep these frayed communities together.

### What to Support

To ensure that history does not repeat itself, researchers, service-providers and practitioners who are not a part of these communities need to pay attention to what these communities already know about what leads kids into trouble and how to support what would work best in these marginalized places. Indeed, it has been suggested that "one important way

for helping professionals to bridge evidence-based and culturally-sensitive treatment paradigms is to partner with indigenous programs in the exploration of locally determined therapeutic outcomes and culturally sensitive interventions that are maximally responsive to community needs and interests” (Garett, et al., 2014, p. 482; see Brave Heart, 2012, Gone, 2009). That is, there is a need for more “community-based participatory research” that can engage and empower community members by helping them identify, create, and “provide intervention strategies compatible with cultural and community values, strengths, and needs” (Garett, et al., 2014, p. 483; see Brave Heart, 2012; Goodkind, et al., 2010; Goodkind, et al., 2011; Goodkind, et al., 2012a). In one such effort, it was found that when youth completed the intervention, “their traditional cultural identity, self-esteem, positive coping strategies, quality of life, and social adjustment increased” (Goodkind, et al., 2012a, p. 398).

At the practitioner-level, it is recommended that “cultural competency training for providers who work with Native youth include explicit discussion of historical trauma and institutional racism, their impact on health disparities, and how to apply this knowledge appropriately” (Goodkind, et al., 2011, p. 469). Further, it has been argued that prevention programs in these communities “will be strengthened if Native parents have opportunities to accept and reconnect or deepen their understanding of effective traditional parenting techniques” (pp. 469-470; see Dionne, et al., 2009; Goodkind, et al., 2012a, Goodkind, et al., 2012b). Moreover, behavioral health interventions should move beyond the individual and encompass the child’s parents, extended family, and community. Indeed, “[f]unding and support for community healing efforts” is needed (Goodkind, et al., 2011, p. 470).

In addition to providing “culturally-based interventions,” there is also a need to “address external barriers that impede the client’s development . . . due to lack of resources, access, or

power” (Garrett, et al., 2014, pp. 486-487). For example, it has been noted that per capita spending on Native American health care is “60% less than is spent on the average American” (Goodkind et al., 2010, p.387; see Goodkind, et al., 2011; Lane & Simmons, 2011). Thus, suggestions for equitable investments include reimbursement mechanisms for “traditional cultural healing practices,” infrastructure to connect behavioral health services with primary care—such as “school-based health centers”—, prevention programs for “trauma exposure” in Native communities, and a shift from evidence-based practices to culturally appropriate “practice-based evidence” (Goodkind et al., 2010, pp. 388-390).

However, because “practical barriers” such as poverty and transportation issues can impede participation in culturally appropriate interventions, it has been noted that “interventions may need to include increased focus on addressing resource issues and social stressors frequently faced by AI [American Indian] families” (Goodkind, et al., 2012a, p. 400). In this regard, it is tragic to note that Native American communities across the country endure “unemployment rates from 50 to 90% . . . underdevelopment of human capital (education, skills, technical expertise) and limited means to develop it” (Garrett, et al., 2014, pp. 478-479). Clearly, this is not a reflection of equal opportunity. Moreover, discrimination is not only a common experience among Native Americans, it is also linked to a number of adverse consequences (Belcourt-Dittloff & Stewart, 2000; Whitbeck et al., 2001; Whitbeck, et al., 2002).

In addition to paying attention to the insights and concerns of grassroots leaders, this study suggests that practitioners of pre-existing programs can also serve as a resource for transformative solutions. At Mountain View, the emergence of care often occurred in response to slumcare practices and it motivated my colleagues to imagine how things could be improved. Although these attempts to transform the structures they were operating within often encountered

forces beyond their control, their insights could lead to improved services that nurture “social and political awareness” of how larger structures are implicated in the troubles faced by marginalized youth and they can point us towards more collaborative solutions (see Currie, 2013a, p. 9).

### Transformative Agency

During the course of this study, I was struck by how often my colleagues attempted to right the ship. In many ways, the emergence of care was evident at Mountain View. When weak staff facilitated chaos and endangered the residents, naturals would often step in and separate that worker from the kids they were endangering. When it was clear that Daisy—the therapist—was not establishing a rapport with the residents, naturals voiced their concerns and attempted to facilitate therapeutic alliances with the therapist. When Alex—the CEO—realized that approximately 30% of the kids didn’t need to be in a group-home and could be better served with in-home services, he attempted to provide that service even though it was at a cost to the business. When Luna—the group-home manager—was asked for her Native American contacts, she advocated for group-homes to be built on the reservations instead of placing these kids 100 miles from home. Repeatedly, my colleagues used their agency in attempts to transform the structures they were operating within. That is, they engaged in transformative agency.

While many of the kids at Mountain View could have benefitted from culturally appropriate in-home services, some of the kids at Mountain View didn’t have parents or grandparents to go back to and some couldn’t go back because of the dysfunction in their homes. Thus, some type of out-of-home placement was appropriate for a number of the kids. However, the degree of care that was provided at Mountain View wasn’t cutting it. Nevertheless, my colleagues did have ideas about how group-care could be improved.

## Recruit, Develop and Retain Naturals

Instead of assuming that a degree in psychology or social work enables someone to establish therapeutic relationships with Native American youth, the behavioral health field should invest in recruiting, developing and retaining naturals to do group-care work in these communities. As suggested by Alex, this could involve a certification program—offered through colleges or independent organizations—that ensures that direct-care workers have the emotional grit needed to do the work, can provide consistent care and can engage in attentive empowerment. As indicated by my colleagues, qualifications should be based on the demonstration of actual skills as opposed to merely book knowledge of how to intervene with troubled youth. This is particularly relevant in reservation communities as most of this knowledge is based on non-Native perspectives of behavior, emotions, family and culture. Not to mention that it generally erases the history of unjust treatment and collective trauma in its conceptions of behavioral problems.

While this would require a significant transformation of how direct-care work is usually organized in the behavioral health field, successful models for how to establish certification programs already exist throughout the regular healthcare system. Further, rather than allowing providers to instill their own trainings, Tribal standards should be set for the development and assessment of these skills. Those who are likely to resort to aggression, who lack the necessary patience, who don't have a thick skin and who haven't demonstrated a capacity to be resilient, should be screened out.

To the extent that these group-care workers are expected to put their safety on the line and do the extraordinarily difficult job of deescalating angry and aggressive youth, they should be paid salaries that value their abilities as well as their service to their community. To facilitate

natural connections, youth should also have access to a diverse group of practitioners—in terms of age, gender and life experience—that represents the communities these kids come from.

#### Provide Culturally Competent Care

As suggested by Luna, if out-of-home placements are needed, they should be provided in the communities they are intended to serve. Further, as suggested by Beth, Don, and Luna, direct-care workers should also be culturally competent. While training could provide a degree of cultural competence, the best course of action would be to utilize practitioners who know, practice and value the culture of the residents. Further, in keeping with the recommendations of Native American scholars, these practitioners should be trained in how to appropriately create awareness of how collective trauma is implicated in their troubles. Given the diversity of Native American tribes, the specific interventions provided by these group-care facilities should be determined by the tribes themselves. In that regard, funding should be provided for community-based participatory research to develop culturally appropriate interventions.

#### Provide Practical Training

To avoid occupational abandonment, training should focus on the practical realities of the job. According to Daisy and Dylan, direct-care workers should be prepared for the harsh realities they are likely to face. As suggested by Daisy, direct-care workers should be informed of how aggressive and violent troubled youth can be. If practitioners are going to use restraints, Dylan advocated for training that resembles the actual event as much as possible. However, keep in mind that both Beth and Don believed that those who do this work best, are those who can always find a way to deescalate a child without having to resort to a restraint.

In addition to preparing practitioners for the realities they will encounter, Luna, Gary and Alex suggested that practical—on the job—training was needed. According to Luna, “I would

have added one day of coming into the house: on the job training...” Similarly, Gary indicated “I’d like to see twenty-four hours worth of observation in the house before they go on to a regular shift so that they become at least aware of who other staff are and who residents are . . . [and receive] at least some form of coaching and training and development.” Because Alex believed that learning occurs “through practice,” he indicated that “we need people in the homes coaching, developing.” Indeed, Krystal lamented that there weren’t enough seasoned practitioners around to coach new staff.

### Provide Actual Oversight

According to Alex, Tina and Dylan, poor quality care tended to fly under the radar simply because there were significant gaps in the oversight of direct-care work and the provision of therapy. Although the organizational hierarchy was intended to hold direct-care workers and therapists accountable, oversight tended to be sporadic, at best. Considering the degree of harm that can be caused by colluding staff, a system of actual—continuous—surveillance may be warranted.

While cameras could conceivably deter slumcare practices, it would largely provide a reactive means for addressing actual harm. A more proactive solution would be to utilize seasoned naturals to supervise new staff. In theory, Mountain View occasionally utilized a floater position, whereby a more senior direct-care worker floated between the two groups being run by the other direct-care workers. In practice, the constant turnover resulted in very few senior direct-care workers and it often resulted in shifts begin understaffed. However, if the behavioral health field invested in recruiting, developing and retaining naturals, they could be relied on to supervise new staff.

In terms of therapy, it may be impractical to have natural therapists supervise new therapists. However, counterfeit therapy had less to do with the observation of ineffectual therapy than it had to do with the benefit of the doubt given to Daisy's presumed expertise. Given the number of complaints that were made and the extent to which they were easily dismissed, a solution would be to decouple the power of the therapist's position from the interventions that are provided. In other words, if everyone who worked with these kids had a say regarding the effectiveness of the interventions being provided, Daisy would have been held accountable. However, that would have required a different type of organizational structure.

### Cooperative Organization

Repeatedly, my colleagues indicated that ABC suffered from a lack of checks and balances. Indeed, it was often revealed that when power was concentrated in particular positions—such as the CEO and the therapist—there was little recourse when people in those positions made questionable decisions. Similarly, I documented in my research journal how the new manager of Mountain View not only took on a “hands-off” approach—that is, failing to coach and develop new staff—but also seemed to be content with ceding power to the kids as the rules of the house were frequently violated without consequence. Because she was the manager and because she seemed to be disinterested in implementing the basic rules of the house—such as keeping kids under constant supervision and having them empty their pockets when they arrived from school—my attempts to get new staff to follow the rules was an uphill battle.<sup>75</sup>

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<sup>75</sup> In this regard, the new manager seems to have demonstrated that transformative agency can have a dark side. In this context of concentrated power and minimal surveillance, managers are granted ungoverned authority to transform the structures they are expected to implement. While naturals use their agency to implement changes that benefit the kids, weak staff seem to use their agency to avoid conflict, minimize the work they have to do and place their interests above the kids they are meant to serve.



Ideally, Tina indicated “[y]ou need to bring everybody together who has interactions with that kid to discuss what might be best, because somebody might have a better idea and once that goes away, it gets scary.” In her experience, it would help “[i]f everybody could put down their ‘I have a degree, you don’t’ or put down—you know—‘I’m here, you’re not’ kind of . . . attitude and communicate...” Indeed, Don lamented that when important decisions were made in regards to the residents, direct-care “were never conferred [with]” When I asked him if that was needed, he replied: “absolutely.” In his opinion, frontline staff should have “an input since we do . . . direct-care with them.” Although personalities are bound to clash, Luna reported that practitioners need to come to a “consensus that look, whether you like me or not, it’s not about us liking each other, it’s about the boys.” While such a collaborative approach is counter to the hierarchical structure of most programs, it could solve the problem of concentrated power and facilitate “collective aspirations” (see Currie, 2013a) for the best possible intervention.

#### Time to Invest

While transformative suggestions like these could lead to improvements in group-care interventions, they will remain untapped resources if we don’t actively seek them out. Indeed, there is a need for additional research to explore how practitioners of other group-care facilities could improve their services. To the extent that transformative solutions emerged from an evidence-based ‘conformist’ intervention, it may also be time to consider moving past what works to what is just in all communities that have suffered from unjust treatment. However, because recruiting, developing and retaining naturals to do this work would require a significant investment, none of these suggestions will be implemented unless there is a widespread commitment to invest.

Although the reservation communities implicated in this study remain out-of-sight and out-of-mind, investment in them is long overdue. In light of the collective trauma they have endured, the harm that is caused by imposing culturally inappropriate interventions on their kids, and the potential for unnecessary child removal and child-maltreatment to be re-traumatizing to entire communities, we need to imagine how things can be done differently. Investing in transformative interventions from the ground-up will require an enormous commitment. However, investing in these communities is not only long overdue, it is also a matter of basic fairness and social justice. With that said, consider what Nelson Mandela had to say about children and violence:

[S]afety and security don't just happen: they are the result of collective consensus and public investment . . . We owe our children—the most vulnerable citizens in any society—a life free from violence and fear. In order to ensure this . . . [w]e must address the roots of violence. Only then will we transform... “(Mandela, 2002).”

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