Redefining Residential

One through Eight

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Redefining Residential

The provision of residential treatment to children and youth has been a topic of debate for decades. Its proponents describe the remarkable changes that occur for youth as a result of carefully structured and engineered environments designed to promote understanding, healing, and growth. They recount testimonials from those they have served, now adults, who say that their experience in residential treatment saved their lives, as well as parents who offer similar accolades. Others argue that residential treatment institutionalizes children, takes them away from their home and community, treats them in artificial environments, and in the worse cases abuses them. Policy makers and public officials point out its relatively high cost, but also the necessity that it be available, particularly for those children for whom there appears to be no other recourse.

Over the years the debate has tended to be pitched and at times polarizing. This is at least partially because children and youth referred to residential treatment are those who evoke exquisite combinations of compassion, concern, fear, and frustration, for parents, caseworkers, providers, and public officials. We agonize over the disruption of their childhoods and the overwhelming stress or trauma they have experienced. While they feel helpless and hopeless, our efforts to administer to their needs often seem inadequate and unsuccessful. Residential treatment at its best offers hope that these children can heal in a safe environment and develop skills that will enable them to cope as they mature into adults; it also brings despair at the loss of the type of childhood we wish for ourselves and our children. Parents describe the excruciating combination of relief and guilt they experience when they admit their child into residential treatment: relief at not having to struggle to know what to do day in and day out in response to their child's emotional and behavioral challenges, and guilt at feeling relief for putting their child into someone else's care.

Toward the end of the 20th century the debate over residential treatment tended to assume an insular, "either-or" quality. Residential treatment providers and staff struggled with and at times resisted change while upholding the critical importance of the service and level of care they were providing. In what at times seemed like a separate world others were making broad and categorical statements about abuses in residential treatment and questioning the need for its very existence. Unfortunately the nature of the service itself, as well as lack of funding, precluded the opportunity to perform research that could sufficiently control variables to effectively shine a great deal of light on this discussion. Nonetheless in the face of emerging evidence that both in-community services and residential treatment are critical in a comprehensive system of care, the discussion has drilled into a myriad of nuances and details at the practice and program level. The need for a new paradigm about the role and best use of residential treatment has become clear and present.

This series of papers represents the collective viewpoint of the American Association of Children's Residential Centers (AACRC) regarding practice and programming in residential treatment for children and youth in the early twenty-first century. AACRC is the longest standing national association focused exclusively on residential treatment for children and youth. For over fifty years AACRC has supported the needs of children who require residential treatment and their families through intensive focus on advancing programming and practice for this extremely vulnerable population.

Several years ago AACRC, led by its public policy committee, began engaging in dialogue regarding redefining residential treatment. Underlying this effort was the belief and knowledge that residential treatment was a necessary part of a system of care, along with the belief and knowledge that the practices that have come to define residential treatment over its previous fifty years need to be re-examined and changed in light of what we have learned about helping children and families most effectively. AACRC decided to develop a series of monographs focused on redefining residential treatment, through a process of synthesizing the best thinking and practice in the field.

The process has involved extensive discussion among members of the public policy committee and AACRC's Board of Directors. These are individuals from around the nation who have served in various professional capacities in the field of residential treatment as well as parents of children who have received services. The monographs are intentionally not designed to be research summaries of the literature; this is partially because the literature specific to residential treatment is sparse but more so to capture the richness and potential learning that has characterized the dialogue. The discussions have been truly amazing and it is hoped that the results of them, contained in these short papers, stimulate similar thinking and discussion in policy making and practice arenas alike. Feedback thus far suggests that we have been successful with this objective, as reflected in the commitment in several states to take a fresh look at residential treatment, as well the work of the national Building Bridges Initiative, in which AACRC has played a prominent role since its inception.

The redefining residential series is dynamic. AACRC has identified additional topics for the series which will be added to this compendium as they are developed. It is our hope that doing so will help sustain the ongoing conversation about how best to respond to the complicated needs of our most vulnerable children and youth, and their families.

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Redefining the Role of Residential Treatment

Adopted October, 2005

This paper reflects the viewpoint of the American Association of Children's Residential Centers (AACRC) regarding efforts underway around the nation to redesign the role of residential treatment in local communities. Founded in 1956, AACRC is the oldest national association focused on the needs of children with serious mental and behavioral problems who are in residential or other milieu-based placements. AACRC has approximately 100 member agencies nationwide. The paper will first discuss the background for rethinking residential and then present ideas and considerations for the field, policymakers, advocates, and other stakeholders to incorporate into their ongoing work.

Why redefine residential's role?

Many academicians as well as administrators and clinicians in the field of residential treatment believe that a fundamental rethinking of the role of residential in the service system is overdue. There is a substantial and growing body of research indicating that system of care models have demonstrated effectiveness in providing treatment and support for children with serious mental and behavioral disorders and their families, utilizing in-home, wraparound, and community services. Nonetheless, not all children consistently respond well in open community settings and some need stays in residential care for periods of time. States and locations that have eliminated residential services have experienced increases in hospitalization and/or the necessity to reestablish residential capacity.

Residential treatment, historically, has been viewed as a "placement of last resort", on a linear continuum in which youth have to fail in a series of placements before being eligible for admission. It has been regarded with what might be considered a type of hostile dependency by some payers and child-serving professionals, who decry its cost and question its outcomes, but need its resources for the most seriously troubled children. Residential providers and staff have at times reciprocated, adopting a mindset of being the "only ones" who can help or control the children in care. While national benchmarking data shows that children generally improve while in residential care, the degree to which gains achieved in traditional residential models are generalized have been questioned. Often isolated at the "end" of the service continuum, many residential centers have not developed the linkages for transitioning children back to the community. Discussions about service configurations typically implicitly or explicitly posit an either-or equation (i.e., either residential/institutional placement or wraparound/community care configurations), locking residential into its historical role, and putting the children and their families into a position of bouncing back and forth, in and out. This perpetuates fragmentation and inefficient resource utilization.

AACRC believes that residential and out of home placement settings are critical components of local coordinated systems of care for children and families. The frequent focus of our association's annual conferences over the last five to ten years has been on the critical importance of integral family involvement and community linkages. Many programs are experimenting with "turning residential inside out", deploying the service as a specialized intervention through innovative models which initiate wraparound configurations while the youth is in care and extend residential staff into community settings. Such models enable communities to provide the residential capacity so needed

for some youth, while shortening lengths of stay and translating the specialized expertise of residential into community settings. Where these models exist, the system is more integrated and better able to respond to individual needs of children and their families.

New paradigms-thoughts and considerations

Particularly in tight budget times it is necessary to create new partnerships and paradigms for residential treatment and the system of care. In creating new models, AACRC encourages policymakers and providers to incorporate the following considerations:

- Families and communities have a legitimate interest in ensuring that residential treatment is used only when indicated as part of an array of services available to each child and family. Comprehensive assessment processes should be utilized to determine appropriateness of placement into residential care.

- Many children have not done well in community settings due to behavior and needs that are too demanding for their families or treatment foster care settings. Residential care offers powerful opportunities for helping stabilize child and family situations and creating the "space" for solid planning, based on a comprehensive assessment of the child and family need. It also affords the possibility of "sanctuary" when safety concerns are paramount and the state's protective service agencies or juvenile court system have determined that highly permeable boundaries are not in the child's best interests. For some older youth (age 15+), residential can be the starting point for movement towards independent supervised living.

- It is important to shift the culture and perception in the youth-serving arena so that residential is not seen as a placement of last resort, but rather as a specialized opportunity—an intervention or a tool—to help with a specific set of needs and circumstances. In the current typical scenario, a youth must fail repeatedly prior to referral and admission to residential, when a shorter stay earlier in the youth's trajectory may have helped establish a stronger foundation for system of care supports and interventions.

- Similarly, shifting the perception of residential can help shift the perception regarding the families whose children require care. A residential placement doesn't have to connote failure on the part of the child or the family. Rather, it can be utilized as a clinically-informed or psychiatric respite, an intervention to help a family restore equilibrium or establish greater stability.

- Some residential programs around the nation are moving toward integral involvement in local coordinated systems of care, working in full and active partnership with state agencies, schools, parents, and the community. These pioneering agencies are establishing new models. They are reengineering their organizations, as follows:
    - creating new opportunities and mechanisms for involving families in their child's care;
    - reaching out to parents prior to placement and maintaining active parental involvement in care, organizational planning, and governance;
    - establishing child and family teams, including community members, that are involved in decision making;
    - utilizing capacity fluidly, to include crisis respite, residential assessment and stabilization, and longer-term residential care;
    - changing care planning processes;
    - engaging in new partnerships;
    - facilitating wraparound interventions both during and following residential stays;
    - viewing residential as an intervention, thus shortening lengths of stay;
    - hiring parents whose children were recipients of service;

- sending residential counselors into the community; and,
- inviting community partners to share responsibility and decision-making in supporting the child and family.

- Often children improve while in residential care but have few or no supports upon return to the community. It is critical to ensure that continuing care is available to all children leaving residential care, and is an incorporated component of any funding structure.

- Current federal and state regulation at times works against a system of care orientation. Various key requirements stem from basic assumptions that are institution centered. They tend to prescribe processes and functions, sometimes at a detailed level, rather than outcomes. Federal and state policy can support and promote efforts to develop local coordinated arrays of services through initiatives and regulations that incentivize pooled resources, shared responsibility models, and cross-system waiver designs. The federal and state governments can reflect explicitly in policy the importance of not isolating residential as a service of last resort.

Please contact AACRC (1-877-332-2272) should you wish to dialogue regarding these ideas.

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Redefining Residential: Becoming Family-Driven

Adopted June, 2006

Preface from Parent Advisor Board Members of AACRC *Redefining Residential: Becoming Family-Driven* is a vision for family-driven care. We are excited to have been asked to collaborate with AACRC in creating this document, as the association continues a series of policy papers that highlight new trends and promising practices in residential care. While our discussions at times were difficult, they were a necessary component of building mutual understanding and respect in our parent-provider partnership. The process of creating this paper is a good example of what ideally would happen on a daily basis in partnering with families in the care of their children. The collaborative work and open dialogue that created this document are essential elements of "becoming family-driven". This beginning dialogue must be continued if the redefinition of residential and true system transformation for our children individually and collectively is to become a reality. We hope that with this paper family-driven care has finally arrived, long overdue.
Martha Globus-Rodriguez (New Jersey), Ron Sipress (Oregon), Joe Anne Hust (California)

This paper represents current thinking of the American Association of Children's Residential Centers (AACRC) regarding the importance of family-driven care for youth placed in congregate facilities. AACRC is the longest standing national association focused on the needs of children in residential treatment and their families.

Overview

Residential treatment as a field has struggled with how to effectively respond to the familial needs of the youth in care. In the past the field tended to be youth centered, with family work as one of many identified treatment issues, typically focused on the youth's response to his/her parents and siblings. Parents' involvement ranged from none at all to very active involvement in their child's care; however in general the rights of family members to have access to and be central to their child's treatment was subject to contingency and question.

Residential treatment has not been alone in this clinical heritage; a dismissive approach to families of children with mental and behavioral disorders has also tended to characterize the culture of the child welfare, mental health, education, and juvenile justice communities. Nonetheless residential has a unique and unfortunate legacy of ambivalence about parents, rooted in its history as a service modality that evolved from the orphanage model. In its genesis the field was imbued with the residues of parent surrogacy, an orientation strongly reinforced by the prevailing mindset across the other child serving systems and training institutions- that parents were the cause of the child's problems. Residential became defined, and defined itself, as a placement, in which the staff individually and collectively took the place of parents in the day-to-day life of the child. The understanding and empathy offered the children was not consistently afforded to the parents, many of whom faced stigmatization and adversarial approaches.

In the last two decades, the thinking about family involvement across the child serving systems has begun to change. The Child and Adolescent Service System Program (1985) envisioned a central

role for families in community systems of care for children with mental health problems. Wraparound, family decision making, and parent-professional partnerships have emerged in child welfare, education, medical, and juvenile justice arenas, as well as in mental health. Such service configurations have recently been supported by the research and heralded in salient mental health public policy studies, including the Surgeon General's and the President's New Freedom Commission reports. Research specific to residential care has also consistently identified improved child outcomes when parents and families are more involved. The response from the field to these developments has been slow but not insignificant, as residential centers across the country increasingly design processes and practices for more inclusion of parents and family members in the care of their children. The result has generally been improved outcomes for children and families.

Yet there remains a great deal to do. Residential facilities are faced with redefining their roles in local community systems of care and with the challenge of making the changes necessary to incorporate and support parents and families, often without additional resources, and within a framework of restrictive funding regulations. Many programs have been encountering this implicit or explicit expectation. For some it is transformative, but the task is complex and requires a shift in focus from treating the child in the context of the setting to treating the child in the context of the family and community. The complexity is compounded in responding to those children whose parents' rights have been terminated, who have bounced from temporary placement to temporary placement, and who consequently lack any real attachment to a community. This paper will review the emerging definition of family-driven care in children's mental health and discuss issues related to its implementation in residential programs. Some innovative practices will be referenced and organizational implications addressed.

Redefining Residential – Transforming to Family-Driven Care

AACRC, in a position paper entitled "Redefining Residential 2005", addressed the importance of residential programs reengineering themselves to become integral parts of local systems of care, and encouraged facilities to adopt and adapt transformative practices in keeping with the research and changing external environment. Of these, the move toward adopting and embracing family-driven care offers particular promise and leverage.

Family-driven care is defined by the Federation of Families for Children's Mental Health (www.ffcmh.org): "Family-driven means families have a primary decision making role in the care of their own children …. This includes: choosing supports, services, and provider; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; …" The definition delineates principles and characteristics of family-driven care, most notable of which is that "administration and staff….share power, resources, authority, responsibility, and control…" with families and youth.

There are many important reasons for residential facilities to embark on a path toward family-driven care.

- Children love and value their parents. The biological connection and the drive to heal any disruptions in attachment are powerful. To not explicitly and overtly value a child's parents may inadvertently symbolize not valuing the child. This can compromise the child's self-esteem and jeopardize treatment effectiveness. More importantly such an approach devalues the family relationship, a biological lifetime constant. Even youth who have been estranged and separated from their families often seek reconnection with family at some point in their lives. A treatment climate of shared responsibility, open communication, strengths-focus, and equal partnership facilitates healing and growth.
- The challenges children present in residential care often have genetic/biological components as well as environmental precursors. Children who have suffered trauma in their lives, regardless of

source, often see themselves as helpless at the hands of external circumstances, for which they tend to blame others, including their parents. Marginalizing the participation of parents, in attitude or practice, causes staff to be caught up in the blame cycle, reinforcing the parents' sense of shame or guilt and making it difficult for the children to recover. Conversely, engaging with the family as full partners creates the opportunity for resolution of the losses and grief the child and family have experienced. Ensuring parents have the primary decision-making role supports or, in some instances helps them reassume, their parental responsibilities.

- Parents and families provide important information and feedback. An approach that engages them equally creates a shared responsibility for growth and change. It provides the opportunity for staff to work together with parents and to utilize family members' experience and expertise. This yields an increased ability to understand the child within the context of his/her family, culture and community, and to develop realistic expectations, plans, and supports. The family is affirmed in having their strengths recognized and valued; the staff benefit from having support and assistance and from being relieved of the implicit, at times self-imposed, responsibility to be the ones who will "fix" the child. Family-driven care is a partnership.
- Parent-professional partnerships promote success. They overcome the fear, stigma, lack of support and encouragement, resource limitations, cultural dissonance, misunderstandings, and resistance that parents and professionals alike often experience with each other. They lead to shorter lengths of stay and more efficient utilization of resources.
- Parents are strong and effective voices, advocating in pragmatic and realistic ways for the needs of children on quality improvement, planning, and governance bodies. As political partners with professionals, parents are powerful advocates for the full continuum of care, inclusive of residential, and for efforts to meet the needs of children and families in local communities.
- The research in residential treatment consistently shows that the processes and outcomes of care improve in correlation with the degree of family involvement.

Residential programs have taken notable steps toward family-driven care, and it is probably safe to say that an evolutionary process has been occurring over the past decade. However, old habits, including mental habits, die hard. So despite the evolution that has occurred in the field, there still tends to be collective mindsets in the system and within individual organizations that diminish the importance of meaningful family involvement. The problem is exacerbated by residential's accustomed role as the placement of last resort. By the time families encounter residential providers, the parents are often angry, mistrustful, and/or hopeless, perhaps as a result of their experience in the system, but nonetheless tending to reinforce the "old" mindset where it exists. It is incumbent upon residential programs to develop a culture and practices that help staff to avoid or overcome this mindset and learn how to negotiate working relationships with families at the beginning of treatment in a way that establishes "ground rules", while engaging each family in quite the same manner as each "new" child, as possessing unique strengths upon which to draw in addressing their own particular challenges.

Making and Sustaining the Move Towards Family–Driven Care

Becoming family-driven has been described as "a journey", one that involves constantly addressing the belief systems of the staff, through leadership involvement, training, ongoing dialogue with family members, and self-monitoring (quality improvement). Organizations can consider encountering this challenge at multiple levels of partnership that bring alive the promise of family-driven care. For example:

- **Care** – At the care level parents and/or family members can facilitate treatment planning meetings, work with staff in the milieu, shadow staff in facility and community settings, be the key decision maker in treatment plans, and be consulted over the phone at moments of impasse. Wraparound teams can be configured within residential programs and then follow the family and child back into the community. Focusing consistently on validating strengths can help parents and

families reinforce and develop competencies, at times not identified in referral material or even clearly recognized by themselves. Listening carefully to and learning from parents and families can lead to better understanding of the child, increased cultural responsiveness, opportunities to address the needs of siblings, and the identification of respite and crisis plans for when their children return home.

- **Hired Parents** – Many organizations are hiring parent advocates and parent partners as employees. These individuals can perform a variety of functions within the organization, for example family outreach, staff training, liaison, wraparound facilitation, and mentoring of other parents.
- **Program** – At the program level parents have valuable contributions to offer into quality improvement activities, clinical policy, outreach, hiring, and many other arenas of organizational life. They can provide real life feedback regarding the strengths and gaps of the program.
- **Governance** – At the governance level parents are valuable members of Boards of Directors, and offer critical input into strategic planning and resource allocation.
- **System** – At the system level parents can have important voices on advisory committees and interagency collaboratives. Parents understand the importance of a full array of services and, in telling their stories, have a powerful influence on policy makers.

Such multi-level partnerships can help establish and reinforce a culture of family-driven care. They are more readily supported if the organization has made the leadership commitment to become family driven and can dedicate budgetary resources to supporting parent travel, paying stipends, or hiring parents as paid staff. The Board of Directors and CEO can ask themselves a series of key questions in assessing readiness to move in this direction, for example:

- ✓ *Do the staff of the organization act, speak, and interact in ways that truly welcome, support, affirm, and incorporate the perspectives and wishes of parents?*
- ✓ Do parents have to be “invited” into the organization or is it a baseline assumption of staff that parents are reciprocal partners?
- ✓ *Is the organization committed to redefining itself as providing an intervention within a community continuum rather than as a placement of last resort?*
- ✓ *Does the organization believe that sharing decision-making, leadership, and power with parents yields better outcomes for children and youth?*
- ✓ *Is the organization willing to implement training and other practices that culturally reinforce the importance of parents and families in day to day actions, discussions, and care planning?*

The responses to these questions can drive strategic planning and practice innovation. Changes in practice, even incremental, can and do lead to positive results.

The implementation of family-driven care in residential facilities is a transformational step that promises to yield better outcomes, increasingly shared responsibility, and exciting and rewarding partnerships between professionals, families, and communities. Agencies that have begun the path of innovation have reaped the reward of making their collective work more exciting and somewhat easier. Residential programs are urged to consider taking these steps and to develop practices to sustain them. For further information regarding AACRC, its position on family-driven care, or resources, please contact our national office at 1-800-332-2272.

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Redefining Residential:
Ensuring the Pre-conditions for Transformation through Licensing, Regulation, Accreditation, and Standards
Adopted March, 2007

This is the third in a series of papers regarding the redefinition of residential treatment being disseminated by The American Association of Children's Residential Centers (AACRC). The AACRC is the longest standing national association focused specifically on program and policy issues pertaining to the treatment of children and youth in 24-hour out-of-home group settings. For the past few years AACRC, through its conferences and committee work, has been advancing ideas and showcasing research and innovative programs that highlight the critical role residential treatment can play in community systems of care and the importance of re-engineering and transforming traditional practice models to achieve greater quality, efficacy, efficiency, and effectiveness. This paper will discuss the value of transformation from both the national and organizational perspectives and identify the key foundational structures, already in place in most organizations, that are preconditions for a successful implementation of a transformation agenda.

Transformation – What Is It And Why Bother?

Transformation may be defined as an act, process, or instance of undergoing change, converting to a new form, altering, making over, or renovating. Transformation involves a progression through which an organism, entity, or system fundamentally changes how it appears and how it interacts with its surrounding environment. As applied to service delivery, the President's New Freedom Commission has called for transformational change in the children's mental health system, a process underway in many communities and organizations around the country. Similar development is also occurring in child welfare and juvenile justice arenas.

For residential treatment agencies, and the field, the need to accept the transformation challenge should be obvious. Residential treatment is a powerful intervention with great capacity to impact the lives of children, youth, and families. When marshaled and focused appropriately on the individual needs of each child and the family, this impact can be and often is enormously potent. However all too often residential facilities have been used more as a placement resource, which can potentially lead to less compelling or even negative impacts. What research there is regarding residential treatment strongly suggests that efforts to marshal the unique potential of a residential intervention have not been consistent in the field. This has lead to significant and relatively long-standing debate regarding the viability of residential treatment as a clinical or programmatic intervention and, in many places, efforts to reduce its utilization.

AACRC has addressed the need for transformation of residential in previous papers: Redefining the Role of Residential Treatment and Family-Driven Care in Residential Treatment (available at www.aacrc-dc.org). These have emphasized the potential of reengineering service designs and the importance of "real" family involvement and decision making in the treatment of children in care. Scholarly journals have also recently re-examined the field, in Psychiatric Clinics of North America (2004 Apr; 13(2)) and the American Journal of Orthopsychiatry, (Vol. 76, #3, 2006). The imperative for the field was stated very succinctly at an AACRC conference five years ago: "Change or Die." Blunt though this is, in context it reflects a natural biological process, the evolution through which species or systems ensure ongoing viability. And while the field has evolved significantly since its inception 60 years ago, the current change impetus is toward the transformative leap, morally because the lives of children and their families are at stake, and systemically because of the threat of losing viability. Implementing such a change agenda is an art, an

expression of creativity and vision best achieved and appreciated within a framework of values and constructs and built upon a foundation of learning, experience, and accountability.

The Foundation and Framework for Transformation

A fundamental component, a pre-condition, for transformation is a baseline of standards, processes, and practices to which the organization holds itself accountable. Although varying to a degree between organizations, certain elements are essential in all residential treatment centers, relating to rights, safety, health, and care planning. External standardized criteria, upheld by licensing and accreditation requirements, provide consistency in these vital aspects of care and create the platform upon which organizations can establish internal standards against which to assess performance and consider the possibility of transformation.

- Licensing and Regulation – Licensing creates a core set of expectations to which all programs within a state can be held accountable. Effective licensing requirements help promote client rights, staff competence, quality improvement, and consistent practice. They provide the constants, the solid ground from which innovative and transformative practice can be launched. They also provide a degree of safeguard against the potential of harm to children, events of a type that can undermine efforts to create meaningful change. AACRC requires licensure of its members and is concerned about the variability of practice that can occur in unlicensed settings, which can lead to adverse outcomes for children and their families and criticism of the field. AACRC encourages organizations to work with their state authorities to create meaningful and reasonable licensing frameworks for residentially based services.

- Accreditation –Accreditation is not an effective replacement for licensing, as it typically centers on different processes than those that are the primary focus of licensing and regulation and carries less stringent contractual accountabilities. Nonetheless it is an important accompaniment to licensure. Standards-based accreditation (as opposed to membership-based accreditation) encompasses emerging knowledge and evidence in the field and defines clinical and managerial practices that, done well, result in high quality and effective care.

- Internal Standards and Continuous Quality Improvements- Agency-developed standards, policies, and procedures build upon the framework of licensing and accreditation, implementing unique, mission-driven values and constructs as the foundation for care and innovation. Establishment and measurement of desired outcomes and performance indicators helps each organization assess the degree to which it is fulfilling its own objectives and creates the possibility of comparison or benchmarking with other similar entities on key aspects of care, particularly those identified through accreditation and licensing, or those emerging from national policy discussions, such as the values and practices in the Building Bridges Joint Resolution endorsed by AACRC (www.systemsofcare.hhs.samhsa.gov).

Adherence to licensing and regulatory requirements and compliance with accreditation standards, in conjunction with a quality improvement infrastructure, do not necessarily lead to transformation. Rather, they provide the foundation of safety and best practice necessary to even think about meaningful change. AACRC supports efforts to establish reasonable licensure and encourages agencies to pursue voluntary accreditation and performance measurement, as part of implementing a transformation agenda. The transformation discussion initiated in this and other AACRC papers regarding "redefining residential" is in its early stages. Future papers will examine the many aspects and challenges faced by the field as it evolves in new directions. With questions please contact our office at 1-877-332-2272.

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Redefining Residential: Performance Indicators and Outcomes

Adopted October, 2007

This is the fourth in a series of papers being disseminated by the American Association of Children's Residential Centers (AACRC) regarding the transformation of residential treatment. AACRC is the longest continuously active national association with a focus on clinical issues and programming for youth in 24-hour group treatment settings.

The first three papers examined the preconditions for transformation, the redefinition of the role of residential treatment in the service continuum and the implementation of family-driven care in residential treatment. This paper will discuss the importance of performance measurement and benchmarking, organizational issues and systems related to data collection and analysis, and potential categories of indicators and outcomes for measurement.

Importance of Performance Measurement and Benchmarking

Residential treatment as a field has been criticized in many quarters for not demonstrating results. Whether or not this assessment is entirely accurate is a matter of some debate. The nature of the service mitigates against the tight controls needed for determinations of *efficacy* -the probability that a specific intervention will produce beneficial results under specified ideal conditions. Similarly residential treatment as an intervention encompasses multiple relational and contextual variables that impact clinical *effectiveness*- the probability that an intervention will produce beneficial results for typical clients, treated by the average practitioner, under ordinary conditions. The variables, including the definition of the setting itself, are difficult to define, isolate, and evaluate. Methodology is further challenged by factors external to the agency: fiscal constraints; inconsistent or confounding data definitions and tracking mandates from regulatory entities; and differing payer requirements.

These issues notwithstanding, measurement of performance and outcomes provides a great deal of important information about what occurs within a residential facility, particularly regarding effectiveness. Testimonials about the impact of a residential treatment episode on a child and family are powerful, whether positive or negative, but are anecdotal. Systematic gathering, compilation, and analysis of data regarding the specific children and families served affords important objective information regarding the work that occurs as part of a residential treatment intervention and establishes credibility for individual organizations and the field.

Benchmarking offers an important companion to performance measurement. It creates an opportunity for an organization to compare its performance, as measured on key indicators, with that of other similar entities. While performance measurement can identify effectiveness on a particular metric over time, benchmarking further contextualizes the data, comparing it to that of similar organizations providing care and treatment for similar children, youth, and families. In a culture in which continuous improvement of quality is valued, benchmarking can safeguard against myopic interpretations of organizational performance data and can incentivize the pursuit of excellence. For the field it offers

the opportunity of identifying objectively determined standards and demonstrating individual or collective agency performance against these benchmarks.

A growing number of organizations have invested in performance and outcome measurement and are producing important data about their work. Nonetheless, data collection and aggregation in the field is not systematic, generating a perceived and, to a degree, actual lack of evidence. The work we do is too important to ignore this issue. While the responsibility is shared with payers, government, and academia, we can assert leadership, as individual agencies and as a field, to establish performance measurement and benchmarking systems and practices that yield meaningful information about the results of a residential treatment intervention and key mediating indicators.

Organizational and Industry Challenges

Creating a culture that values and balances quantitative and qualitative information requires careful work on the part of leadership to evoke, support, and sustain key norms and values related to quality improvement and continuous learning. It involves: including stakeholders, especially staff, parents, youth, and community partners, in indicator identification and system design; ensuring that indicators are supported by available evidence and that the data collected is relevant; establishing and sustaining cost-effective and efficient information systems; reinforcing data-driven process improvements; and using the products of performance measurement and benchmarking to provide timely feedback and to support staff in their work.

The literature on organizational development offers a resource to residential facilities that identifies approaches to the creation of such a culture. Financial wherewithal is often an issue, but the investment is critical if an organization is to improve its programs, effectively demonstrate the effects of its work, market its services, and garner staff and community "buy-in". Sustaining the effort depends to a significant degree on the establishment and renewal of meaningful indicators that are aligned with the mission, vision, values, and philosophy of the organization and with licensing and accreditation standards.

The challenge for the field is to help establish common data sets across organizations and states. Although efforts have been confounded by difficulties agreeing upon data definitions and measurement specifications along with concerns about comparing programs serving differing populations, a set of broad outcome and indicator measures is emerging. The opportunity is ripe for the field of residential treatment to develop and/or embrace national indicators addressing the work occurring in programs around the country.

Frameworks for Indicator Development

As residential programs implement or refine their performance measurement systems, a basic framework may be helpful in guiding the identification and development of indicators and determining benchmarking priorities. One such framework contains four categories:

- Practice/Process Indicators – These measure processes and practices of care that occur in the course of a residential treatment episode, for example: areas that are problem prone, of high risk, or representing worrisome patterns (e.g. seclusion and restraint, medication management, elopements, incidents, and injuries); dimensions of family and youth involvement such as family inclusion in the milieu, youth participation in treatment, parent contact; continuum of care factors such as access to services and supports, participation of community partners, continuity of care, timeliness and comprehensiveness of diagnostic assessments, and discharge planning; and/or activities/practices sub-grouped by life domains (i.e. emotional, psychological, physical, social, academic, medical, nutritional, legal, spiritual, cultural, vocational).
- Functional Outcomes – These indicators reflect change in the child's level of functioning, either during a residential episode, or afterwards as a result of the treatment intervention, as measured through valid and reliable instrumentation and processes. Family and community

expectations are important considerations in identifying meaningful functional outcomes, which might include restrictiveness of living environment, school performance, legal involvement, peer relationships, severity of illness, etc.

- Perception of Care – These indicators measure the response and satisfaction of children, families, and the community regarding the services provided, using internally developed and/or nationally normed instruments.
- Organizational Indicators – These are measurements of organizational phenomena such as staff retention, job satisfaction, work environment, fiscal performance, safety programs, etc. These important dimensions of performance directly impact the quality of care, and can be correlated with practice, functional, or perception indicators.

A useful taxonomy is being developed through the national Building Bridges initiative. This conceptualizes indicators related to the "bridges" between residential treatment and the family and community, organizing them chronologically: referral/admission; "during" residential treatment; discharge/transition; and throughout the process. The matrix differentiates standards- the presence of a set of conditions related to treatment- from indicators of quality that can be directly measured. It incorporates the categories identified above in one integrated design that can yield a common data set across the field but still allow for individualization within organizations.

Measurement for a Redefined Residential

Excellent work has been occurring in various places around the country to reconceptualize the role of residential treatment within the continuum of care and to design mechanisms with which to integrally link a residential intervention with other community services. As part of this work performance measures and outcomes that might be expected of a residential intervention are being proposed. Additionally the importance of collecting, aggregating, and analyzing data to allow for comparisons among providers of similar interventions across the system of care is being emphasized. The Building Bridges initiative, in which AACRC members have played important leadership roles, offers an opportunity for the field to come together in focusing its work on broadly shared goals and practices and in developing/implementing common measurements, in alignment with emerging federal and state policy, that demonstrate its importance and effectiveness, as well as its opportunities for improvement.

AACRC believes that its member agencies and other residential facilities around the country must proactively embrace the challenge of performance and outcome measurement and benchmarking. Many are already doing so and have been for some time. Expanding this effort individually and collectively will help organizations firmly establish a redefined role in community systems of care, increase viability and credibility, and most importantly, improve quality and results for children and families.

With any questions please contact the AACRC office at 1-877-332-2272.

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Redefining Residential:
Integrating Evidence Based Practices
Adopted October, 2008

This is the fifth in a series of papers being issued by the American Association of Children's Residential Centers (AACRC) regarding key program and policy issues facing the field of residential treatment. AACRC is the longest standing national association focused exclusively on the needs of children who require residential treatment and their families. Over the past several years AACRC has engaged with national policy makers, family members, youth, and its membership in an effort to redefine the shape and scope of residential treatment as an intervention for youth with serious emotional and behavioral disorders and their families.

This paper addresses issues related to the use of evidence based practices in residential treatment. It will address the national context, issues specific to residential treatment, and ideas that organizations can consider as they encounter policy and program challenges.

Current Context
There is increasing demand at the national and state levels to address the effectiveness of services provided to children and families. At the national level major reports from the Surgeon General (1999), the Institutes of Medicine (2001) and the President's New Freedom Commission (2003) have identified the gap between research and service delivery, and have recommended closing it through timelier implementation of practices supported by research-based evidence. Federal agencies have responded with the development of a "tool kit" regarding specific practices found to be advantageous in working with children with disruptive behavior disorders as well as a resource guide for establishing evidence based cultures in the child serving system. Several states have passed laws or implemented policies fostering the introduction and implementation of evidence based practices (EBP).

However, many competing definitions of EBP are offered by clinicians, researchers, and constituencies. The most scientifically rigorous of these is:

> *"…identified through at least two control group design studies, with a minimum of two investigators, employing a treatment manual, with uniform therapist training and inherence…"*

Other definitions take a broader view. The Federation of Families for Children's Mental Health (FFCMH) has defined evidence based practice as:

> *"child and family history and experience of what works and what does not."*

A definition that incorporates these and others has been advanced by the American Psychological Association (2006):

"the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences."

Additionally key constituencies have raised concerns about emerging EBP policy and practice.

-Family members express apprehension that EBP have been developed in controlled settings with specific populations and/ or in specific locations, and may not be sufficiently individualized or culturally appropriate. They assert the importance of practice based and community defined evidence, bottom up approaches that incorporate knowledge of what has worked or might work in their families in real clinical and community settings.

-Cultural and ethnic groups are concerned about the lack of EBP for ethnic/racial populations as well as the lack of inclusion of these populations in current development or replication studies. They assert the need for more effort focused specifically on discovering information that already exists in cultural communities about what has worked over the course of time.

-Practitioners, whether working in individual practice or within an organization, find adherence to manualized interventions problematic. They express concerns about the replacement of clinical judgment with approaches that have fixed content, fixed intensity, and fixed duration requirements. Some practitioners have argued that the exclusion criteria employed by EBP limit the ability to use the intervention for children who do not neatly fit into a specific diagnosis, or who meet criteria for multiple diagnoses.

-Researchers have reached varied findings regarding the variables affecting outcome. While the clear demonstrated effectiveness of interventions tested and twice replicated in randomly controlled trials is compelling, there is also extensive research that client factors, the alliance between the clinician and the client, and the impact of perceived hope account for a greater degree of the change than the specific model or technique used.

-Organizations face multiple challenges in implementing EBP. Although research has indentified a number of organizational variables that affect the degree to which an EBP will be effective, the relationship between organizational characteristics and implementation is typically not addressed in the studies. Administrators point to these issues as well as to the costs of implementing EBP, maintaining fidelity, training, and retraining.

Important efforts are occurring to address these challenges. The APA and others speak to the importance of "practice based evidence", defined as:

"…a range of treatment approaches and supports that are derived from and supportive of the positive culture of the local society and traditions…and accepted as effective by the local community, through community consensus...and (that) address the therapeutic and healing needs of individuals and families from a culturally specific framework.." (Isaacs, Huang, & Echo-Hawk, (2005)

Similarly, increased attention is being focused on evidence based thinking, a process through which decisions are made in collaboration with the child and family based on what is known about the best available clinical practices, informed by data regarding client progress and outcomes.

Recent research has highlighted the "common elements" approach, in which specific techniques and procedures that are common to evidence based treatment protocols are identified and distilled into smaller practice elements, allowing practitioners the choice to either use the protocol in full or use the discrete practice elements (Chorpita, Becker, and Daleiden, 2007). This approach enables treatment

plans to be built based on the correlation between specific practitioner-child interactions (time-out, cognitive, etc.) and broad diagnostic problem areas (e.g. anxiety, depression, attention, conduct).

New models are being developed to synthesize these various approaches to EBP, by designing treatment plans (following a comprehensive assessment) that integrate information from:
-evidence based practice research (*i.e. which models have been shown to work*),
-common elements research (*i.e. what specific intervention elements have proven effective*),
-practice-based evidence (*i.e. what has worked in this community, with this culture, and/or in this organization*), and
-case specific evidence (*i.e. what has worked or is working with this child and family*).

Implications for Residential Treatment
Regardless of the varying definitions of EBP, the "gold standard" that needs to be met for an intervention or model to be formally accepted as an EBP is the most rigorous of those referenced above (e.g. twice replicated controlled studies, treatment manual, etc.). Given the nature of residential- the exponential number of interactions that occur within milieu settings that contain a significant number of children for varying lengths of stay and adults that vary by shift- along with the variability between programs, it would be a research challenge of monumental proportions to establish the controls necessary to prove the evidential basis for residential treatment per se to be recognized in the scientific and policymaking communities as an EBP. The challenge for the field thus becomes how to engage the current and upcoming EBP mandates productively, redefining residential as a multimodal intervention, invaluable for specific children and families at specific times, which incorporates specific evidence based practices as well as practice based evidence in the interactions that occur between staff, children, and families.

Doing so is not easy. Residential treatment programs are more than mere places; they are settings that contain and sustain unique cultures. As such, implementation of some evidence based practices as part of ongoing programming may not fit within the existing culture of the organization. The multi-variant human interactions in an environment as complex as a residential treatment milieu have the potential to confound implementation of EBP. Additional challenges are created by the costs of EBP. Some models have significant upfront and ongoing training costs that are compounded by costs associated with training and retraining of staff, turnover, and administrative overhead.

These challenges notwithstanding residential agencies across the country are making efforts to implement EBP. These include: adding client-specific models (such as dialectal behavioral therapy and trauma informed cognitive behavioral therapy) into their programming; introducing milieu-wide interactive approaches (such as motivational interviewing and collaborative problem solving); and working with community partners to send youth to evidence based treatments offered in community settings. However, the degree to which any or all of these approaches are integrated into a residential treatment intervention that remains coherent to the youth and family, and that honors youth and family choice, varies and there are not currently studies that compare their effectiveness and outcomes.

Embracing the Challenge
Although it may seem inarguable that basing our work on what has shown to be effective is obvious, many residential treatment organizations find the challenge of implementing evidence based practices daunting, even (for some) overwhelming, related to the multiplicity of factors noted above. The emerging consensus among professionals, parents, and policy makers alike suggests that the development of cultures within residential treatment organizations that embrace evidence based practice and practice based evidence, will do much to achieve the ultimate goal of improved outcomes as a result of services.

Such cultures would support and encourage evidence based thinking as defined above- collaborative decision making based on what is known about best practices, informed by data about individual

client progress. As a foundation they would implement and/or sustain the critical elements that have been shown to produce positive impact in residential treatment, in particular a healthy, safe environment with informed and knowledgeable staff who know how to interpret and respond to language and behavior in such a way as to develop therapeutic relationships that offer hope and recovery.

Organizations can take (or sustain) several actions that will facilitate the establishment of an evidence based culture and enable them to respond to the EBP challenge while promoting improved performance and outcomes. A few are noted below.

- Create an organizational climate that nurtures and sustains a positive perception of the workplace and the importance of evidence based thinking among all staff.
- Ensure that service plans are based on: a high quality assessment; a reasonable belief derived from research or quality improvement data that the services will be likely to succeed; the preferences of the family and youth and objective monitoring of progress with revision of services and approaches based upon results.
- Utilize information available on the internet and the variety of other sources to identify approaches that have been shown to be successful with the individuals the organization serves based on gender, race, age, problem areas, etc.
- Require individual and group treatment planning and programming to be purposeful and informed, with decisions based on objective evidence.
- Routinely review clinical and organizational practices to determine current effectiveness.
- Work with staff and clients to meaningfully integrate specific evidence based models for specific populations that the agency serves while simultaneously being careful to not provide such EBP to individuals where there is not a service fit.
- Identify key practices within manualized approaches that may be effective for specific individuals or populations served, while also assessing the effectiveness of the practice if delivered separate from the rest of the model.
- Implement common elements research to help precisely tailor individualized plans.

Conclusion

AACRC urges the field of residential treatment to embrace the EBP challenge and to develop evidence based cultures. Doing so will strengthen the emerging emphasis to redefine residential as an evidence based ecology within which careful multimodal work is being done to effectively meet the needs of the children and families being served. AACRC also urges funders and policy makers to indentify and support such efforts in the financial and regulatory environments. Doing so would not only be sound from a policy and business perspective, the needs of children and families in our country demand no less.

Please feel free to call AACRC should you have any questions at 877-332-2272.

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Redefining Residential:
Family-Driven Care in Residential Treatment – Family Members Speak
Adopted October, 2009

This is the sixth in a series of papers issued by the American Association of Children's Residential Centers (AACRC) regarding emerging and best practices in the field of residential treatment for children, youth, and families. AACRC is a long standing national association focused exclusively on practice and policy issues related to the provision of residential treatment. The "Redefining Residential" series is an effort by the Association to stimulate dialogue that can lead to more effective use of this critical and specialized resource in communities around the country.

One of the earlier papers in the series addresses family-driven care in residential. Its central premise was that a critical direction for organizations providing residential treatment is to move beyond engaging families to drawing upon them to help guide and drive treatment. Such an approach is supported by: 1) research that child outcomes are positively correlated with the degree of family involvement ("Family Centered Residential Treatment: Knowledge, Research, and Values Converge"; Journal of Residential Treatment for Children and Youth, Vol. 25(1), 2008); 2) important biological and philosophical considerations regarding family attachments; and 3) promising practices being piloted by agencies around the country. That paper offered practical steps organizations can take to become family-driven.

AACRC subsequently created a track regarding family-driven care at its annual conference in San Diego in October of 2008. Family members caucused and generated input to the AACRC Board regarding actions the Association and the field can take to more fully actualize the vision of family-driven care in residential treatment. This paper summarizes that input.

About the system

Family members recognize that residential treatment organizations and the field in general don't operate in isolation, and that long-term meaningful system change requires a different mind set and hard work on many different fronts. They know that residential treatment providers are unable to control many variables but believe nonetheless that individual organizations and the field can be effective at promoting and leveraging change. Specific arenas and approaches to more fully implementing family-driven care in residential treatment include but are not limited to the following:

Legislative & Regulatory - Many states are undergoing system change or "transformation" efforts of one sort or another. It is important to advocate for statute and rule revision at the state and federal level that would:

- Mandate funding for provision of peer support, i.e., hired (family members who provide parent to parent peer support, assist parents in navigating the system, and also advocate from the family perspective within the system).

- Eliminate requirements that parents voluntarily relinquish custody to receive services;
- Create flexible funding mechanisms to address individualized clinical and support needs for which there is limited funding available;
- Ensure an adequate range of services and supports so that children do not implicitly need to "fail up" to receive necessary help; and
- Enable residential treatment providers to work with foster parents to mentor biological parents if needed, with the ultimate goal of the child returning home.

Higher Education – Family members are concerned that existing higher education curricula do not consistently train students about emerging best practices. Residential treatment programs may be in a unique position to exert some influence on institutions of higher learning, since many agencies have established relationships with universities and provide internships and practicums for their students. Individual organizations and the field can effect curriculum development by working with the education establishment to:

- Train professionals on the importance of authentic family engagement, developing a trusting relationship with families, the positive outcomes associated with meaningful family involvement , how to encourage family voice and ownership, and the value of family – professional partnerships;
- Move away from defining treatment strictly as child-centered and embrace the concept of seeing children in the context of their family;
- Involve families in the development of training as well as having family members co- train social workers, therapists, psychologists, educators, and psychiatrists;
- Encourage family member and youth input and knowledge regarding family-driven and youth-guided care through internships, practicums and curriculum development activities in social work, counseling, and psychology programs; and
- Appoint "parents in residence" to teach in classroom and field settings.

Advocacy – Family members often make the best advocates by sharing their stories in the hope of impacting positive change and growth in the system. Residential treatment organizations and associations can capitalize on this by:

- Inviting family members to join the Boards of Directors of state and national associations in sufficient numbers so as to not be mere tokens;
- Advocating for the infusion of family members at all levels of the system, on the boards of residential organizations, community advisory committees, university curriculum and program committees and accrediting bodies;
- Conducting public relations campaigns regarding the importance of family-driven and youth-guided treatment, with personal stories about family and youth resiliency; and
- Focusing advocacy on the real human interest stories of challenge and recovery, as well as the lack of financial resources.

<u>Providing Services</u>
Change at the systemic level can't happen in isolation and won't automatically generate change at the service level. In fact, the more meaningful change for any child and family is at the point of service. There is much residential providers can do to become family-driven in their service delivery. While there is an emerging body of information regarding transformative changes that can occur in the provision of residential treatment services, the family caucus offered some specific thoughts and suggestions, as summarized below.

Mindset – Residential treatment, similar to child-serving professions in general, struggles with a mindset in which parents are categorically seen as the cause of the problems that children have. The

cultural change involved in shifting mindsets within an organization and its constituent community system is challenging but doable. Family members have suggested that residential treatment organizations:

- Work with family members to develop language primers that differentiate stigmatizing from supportive and descriptive ways of talking about families and children;
- Establish expectations regarding joking or irreverence that is or could be perceived to be at the expense of the children and their families;
- Provide customer service training that helps staff learn to approach clients and family members in the same manner as that which they would like to experience from a business from which they might personally be purchasing goods or services;
- Utilize parent panels, parent partners, parent advisors, etc., to help staff develop empathy for families and not approach them with condescension or judgment;
- Hire parents who have raised or are currently raising children with emotional, behavioral or mental health challenges and have had previous experience navigating the child- serving system; and
- View families as appreciative allies and collaborative partners.

Communication - Family members often feel that communication with residential treatment providers is confusing or lacking. Some steps organizations can take to address this issue include:

- Have live phone attendants to add an element of warmth and personal connection;
- Return phone calls promptly and as promised, remembering that the urgency is greater for the family member than it is for anyone else associated with the child;
- Establish reciprocal communication patterns in which families are invited to communicate their personal journeys and staff are supported in being open to hearing and learning from parents and family members; and
- Ensure linguistic competence in the organization by having translation services available and by training staff to speak plainly, minimizing the use of jargon and acronyms.

Parent Support – Parents raising children with emotional and behavioral challenges have typically not had the right amount of support, at the right time, and for the right price. Staff in residential treatment often feel similarly- that they don't have sufficient support for their work. There is much that can be done to help staff and parents draw upon each other for mutual support, particularly if organizational values highlight that staff and parents share the same priorities and that the parents and youth have experience and knowledge to contribute, just as the staff have expertise to offer. Some possibilities:

- Provide a direct line to an identified staff member or peer support specialist for parents to call when they don't know what to do during home visits, without having to go through telephonic prompts;
- Inform parents fully of all practices in the organization and be open with them when problems or stresses are occurring;
- Show warmth and hospitality- create a warm welcoming environment;
- Provide enhanced on-call support during transition and post-discharge periods;
- Call parents to ask for advice and support when their child is having difficulties as well as to let them know when their child is doing well;
- Ask parents to speak on behalf of the organization to grant makers, policy makers, legislators, payers, etc.; and
- Ask parents and staff to plan and put on events together (picnics, celebrations, etc.).

Skills - Family members often prefer direct hands-on assistance developing skills for interacting with their child over more formal therapy types of activities. Imparting skills to family members can be directly integrated into residential treatment practices. For example:

- Bring parents into the milieu and let them shadow staff to help them learn skills to use when the child and youth return home;
- Send staff into the home and community to provide skills training services and supports for helping parents and youth learn and practice skills in their day-to-day environment;
- Ask staff to role play or model a wide variety of skills, in milieu, home, and community settings, including how to intervene, de-escalate situations, etc.
- Focus on "soft" skills, real world skills that children and families will be able to operationalize after transition back to the community rather than skills that are useful in the milieu but not necessarily applicable in community settings; and

Simple yet Powerful

Many residential treatment facilities already use many of these approaches. But from the perspective of family members collectively they are not used often enough and unnecessary distances exist between parents and staff. Systematically implementing relatively simple and basic practices such as these can help an organization or system become more family-driven. As this occurs, new synergies will be created that will lend support to this very difficult work and improve outcomes. AACRC urges its members in residential treatment facilities around the country as well as national accrediting organizations, graduate schools and state child welfare and mental health departments, to consider and implement these ideas and become aware of others as they endeavor to continuously improve the work that they do.

For more information please contact AACRC at 877-332-2272.

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Redefining Residential: Youth Guided Treatment
Adopted April, 2010

Preface from Youth Advocates *Redefining Residential: Youth-Guided Treatment* is the outgrowth of a partnership between AACRC, CAFETY (Community Alliance for the Ethical Treatment of Youth; www.cafety.org), and YouthMOVE (Youth Motivating Others through Voices of Experience; www.youthmove.us). We are excited to have been asked to collaborate with AACRC in creating this document, as the association continues a series of policy papers that highlight new trends and promising practices in residential care. The collaborative work and open dialogue that generated this document are essential elements of "youth-guided treatment" and a good example of what ideally would happen on a daily basis in partnering with youth. We expect this dialogue to continue as we work to achieve redefinition of residential and true system transformation, and hope that this paper helps organizations across the country move in this direction.

This is the 7th in a series of papers from the American Association of Children's Residential Centers regarding key program and policy issues facing the field of residential treatment. AACRC is the longest standing national association focused exclusively on the needs of the children who require residential treatment and their families. Over the past several years AACRC has engaged with national policy makers, family members, youth, and its membership in an effort to redefine the shape and scope of residential treatment as an intervention for youth and their families.

Over the past decade the importance of engaging youth in guiding their own treatment and helping shape the system of services and supports has become increasingly evident. Youth have become involved in national, state, and local policy arenas and have developed organized youth driven advocacy groups. Through these activities they have identified effective practices to meaningfully involve youth in improving outcomes in various service settings, including residential treatment. AACRC featured youth guided treatment as the keynote theme of its 2009 conference, which included a youth caucus that presented recommendations to the membership.

This paper emanates from those discussions. It identifies concerns youth have had with the traditional provision of residential treatment, offers a definition of youth-guided care, examines issues related to implementing youth guided care in residential treatment, and offers specific ideas and steps organizations and the field can consider as we strive to continually improve our work.

Youth Concerns

Young people who have been placed in residential settings recognize that residential providers typically operate with the best interests of the young people they work with at heart. However youth are concerned that providers and staff in residential programs are often not open to the idea that their

approaches and interventions may not be ideal, even in the most extreme situations when the measures being used upon the young people in their care are abusive. While such cases may not typify the field of residential treatment, they do highlight legitimate and serious practice concerns.

Residential providers often hear the praises of alumni for the help they received. Less often do the criticisms of youth past and present get the same attention. These youth express a variety of concerns that they feel residential providers did not and do not hear. For example:

- Youth have often experienced staff attitudes and approaches that are patronizing and infer that the youth in care do not understand themselves as well as, or better than, the adults; this finds expression in decision making that not only doesn't include the youth but dismisses the possibility that they might have valuable ideas, perhaps even better than those of the staff.
- Young people often have not experienced meaningful opportunities to discuss or question placement or to be engaged in formulating and carrying out their own treatment plans. They find themselves left with the choice of complying with a set of provisions into which they had no input or complaining, which could jeopardize their privileges or movement toward discharge. They ask that there be "nothing about us without us".
- Point and level systems used in many residential programs are arbitrary and not responsive to their individual needs or relevant to real-life situations they will be in after discharge.
- Behavior that in many settings would be seen as "normal" is viewed as pathological.
- Staff responses to behavior are at times coercive and induce stress and fear.
- Communication with families and friends is seen by staff as a barrier to treatment.
- Treatment philosophies and approaches don't always take the values of individual youth nor those of the youth culture into serious consideration.

Residential programs have taken notable steps toward addressing these concerns and implementing youth guided care. While it is probably safe to say that an evolutionary process in this direction has been occurring over the past decade, old habits, especially mental habits, die hard. So despite the evolution that has occurred in the field, there still tends to be collective mindsets in the system and within individual organizations that diminish the importance of meaningful youth involvement. The problem is exacerbated by residential's typical role as the placement of last resort. Youth entering residential may feel beaten down, cynical, and untrusting due to their experiences thus far, and not receptive to good-faith efforts that may occur to encourage them to participate in their own treatment. Implementing youth-guided care can help mitigate or even eliminate this circumstance.

<u>What is Youth-Guided Care?</u>

Youth-guided care has been defined as follows:

> *"Youth guided means that young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives as well as the policies and procedures governing care in their organizations and/or communities. This includes giving young people a sustainable voice, being listened to, and the focus should be towards creating a safe environment enabling a young person to gain self-sustainability in accordance to the cultures and beliefs they abide by. Further through the eyes of a youth-guided approach we are aware that there is a continuum of power that should be given to young people based on their understanding and maturity in this strength based change process. Youth guided also means that this process should be fun and worthwhile." (www.samhsa.hhs.gov)*

Youth-guided care represents a mindset that can be adopted regardless of the age of the child or youth, one that encompasses consideration and appreciation of each individual as well as awareness of and respect for age, culture, language, and developmental level. It is the first step in the spectrum of youth involvement, one that also extends to youth-directed and youth-driven services.

<u>Implementing Youth-Guided Care</u>

So what would youth-guided care in a residential treatment program look like? A key factor is creating a culture at both the care and organizational levels that embraces the importance of engaging the youth in shared decision-making and problem solving. At the care level, it may be helpful to contrast examples of youth-guided care using the three phases outlined in the Matrix of Performance Guidelines in the Building Bridges Initiative (www.buildingbridges4youth.org), with what youth often experience in "traditional" residential treatment.

Entry phase –Most often the decision to place a young person in a residential program is made without any conversation with the youth. Although the reasons for the placement decision may be seemingly obvious to all involved, the child/youth is not given the respect of being provided with information about where they are going or specifics about the program. In youth-guided practice:

- ✓ the young person is an active participant in the evaluation process, informed with understandable and complete information about all effective treatment options and available alternatives, and engaged in decision-making that respects and considers his/her perspective;
- ✓ the young person is paired with a peer advocate (a young person who has experience in a residential program themselves) so that the young person can have the necessary support to feel comfortable speaking their mind;
- ✓ intake and engagement protocols solicit active participation by the child and peer advocates.

Treatment phase – The degree to which youth are engaged in determining their own course of treatment is variable across agencies, but often they are passive recipients, with adults setting their goals set for them based on the reasons for their placement. This has some logic, as whoever placed the child may require specific attention to remediation of specific deficits. Nonetheless treatment progress and outcome improve with a strengths-based approach in which:

- ✓ the client is able to identify what they want to accomplish during their stay and to voice their thoughts about the best way to achieve their goals;
- ✓ disagreements are addressed through problem-solving dialogue.

At the very least engaging the youth in this way conveys respect, which over time facilitates the development of self-determination skills that will serve the individual well as they get older. This positive impact of youth-guided practice occurs regardless of the child's age, although of course the nature of the involvement will be different based on the youth's age and developmental level.

In many places treatment is still based on a "program", with stages, levels, or other structured elements that are not truly individualized. In youth guided treatment planning:

- ✓ staff responses to specific circumstances are individualized, not driven by a set of group-wide guidelines or "default" consequences or levels that may not fit the situation and may be experienced as unfair and arbitrary;
- ✓ each youth and family is engaged in determining all aspects of the individualized plan including what responses to his or her behavior will likely be most effective, the timing and purpose of visits, skill building activities on campus and in the community; etc.
- ✓ programming uses the peer group in conjunction with staff to identify community activities and skill building opportunities likely to be beneficial;
- ✓ staff are trained to focus on strengths and on how to resolve disagreements such that youth concerns are heard and responded to without dismissing adult concerns.

Transition phase – In traditional residential settings graduation from a program is often based on the completion of a step or level program, not necessarily on an ongoing process of evaluating whether the youth is ready to return to the community. Youth at times feel as if they've been dropped into a chasm, without having had a chance to work with residential staff, their families, or community providers to plan a careful transition into their next living situation. While it is often required that discharge planning starts at intake, this doesn't always occur, and youth are not integrally involved in designing their discharge plan. In youth-guided care:

- ✓ youth are regularly engaged in conversation regarding the discharge plan and in identifying

the services that they feel would benefit them;
- ✓ youth are afforded choices to extend or reinitiate services that may have been helpful during the residential treatment phase once they return home.

Beyond, but related to, these phase-specific provisions, it is critical that organizations create as normative an environment for young people in their care as possible. This includes
- ✓ supporting practices that promote integration into the community;
- ✓ creating opportunity for activities with peers in the community (e.g basketball league);
- ✓ having an educational component that fosters full development of young people's abilities;
- ✓ permitting more open phone privileges, progressively independent access to social media, and visits from friends approved by the family and team;
- ✓ ensuring that programming is culturally and linguistically competent and attuned;
- ✓ allowing young people to fail safely so as to facilitate learning and growth.

The key to creating such an environment is involving the youth in the conversations regarding what will and won't be permitted, in a manner in which both youth and adult concerns are heard, understood, and considered in arriving at mutually acceptable decisions.

Youth-Guided Care at the Organizational Level

Moving towards youth-guided care is not simply a matter of taking a series of actions but requires creation of an organizational environment in which staff recognize the realistic limitations of their understanding and power and nurture an appreciation of positive youth culture. Whether or not the youth and families they serve meet the goals for which they came to treatment is ultimately up to the clients; the organization and staff in reality have very little contingent control over the outcomes. Accepting that the youth might understand themselves as well or better than the adults and sharing power toward fulfillment of responsibilities and expectations can create a culture in which youth-guided care can flourish and the difficult work can become more readily accomplished.

Beyond involving youth meaningfully in their own goal-setting and in determining programmatic guidelines, engaging them in organizational processes can also yield transformative changes. Specific practices that can help providers move to being youth-guided include:

- ➢ Including youth in staff interviews, with meaningful input into hiring decisions;
- ➢ Having youth participate in the training of new staff as both trainers and participants;
- ➢ Hiring a peer advocate to help youth understand the "system" and voice their preferences;
- ➢ Organizing youth advisory councils or an empowered student government that not only provides input but is empowered to carry out agreed-upon actions to resolve issues;
- ➢ Adopting the Youth Bill of Rights (available at www.youthmoveoregon.org)
- ➢ Appointing alumni of the program to sit on the agency's Board of Directors.

Taking steps such as these along with those at the care level will enhance organizational climate and performance, and, most importantly, lead to improved outcomes for the youth and families served.

AACRC encourages residential treatment providers to implement policies and practices that will yield further steps toward the transformation to youth-guided care. The AACRC website identifies links to staff training and other resources that can guide and facilitate this process. For more information please access the site at www.aacrc-dc.org or contact AACRC at 877-362-2272

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Redefining Residential:
Trauma-Informed Care in Residential Treatment
Adopted December, 2010

This is the eighth in a series of papers by the American Association of Children's Residential Centers (AACRC) addressing critical issues facing the field of residential treatment. The purpose of the papers is to stimulate dialogue and self-examination among organizations, stakeholders, and the field. AACRC is the longest standing association focused exclusively on the needs of children and youth who require residential treatment, and their families.

A significant number of children and youth served in residential treatment programs have suffered overwhelming stress and trauma prior to placement. Residential programs have typically striven to create safe, comfortable, and nurturing environments in which children could work through issues and develop new skills, but have also implemented practices and interventions that have at times had the unintended effect of retraumatizing the youth or triggering traumatic reenactments. Many organizations have implemented changes to become more trauma-sensitive, but it is important that programs keep pace with the advances in knowledge generated by the explosion of neurobiological research in the past decade.

This paper summarizes opportunities that residential treatment centers have to improve outcomes and meaningfully support the children and families they serve by taking steps to develop and implement trauma-informed care. It will address key definitions related to traumatic stress and trauma-informed services pertinent to residential treatment and will briefly identify steps treatment facilities can implement at the organizational, environmental, programmatic, and child levels.

Conceptualizing Traumatic Stress

The commonly accepted understanding of trauma is that it relates to specifically identifiable personal experiences of psychological or physical violence, including discrimination, sexual abuse, physical abuse, medical mistreatment, and/or witnessing violence, terrorism, and disasters. However trauma is not necessarily incident-based. Rather the manifestations of trauma can also be generated by less clearly identifiable, subjective experiences of day-to-day life, by challenges in the interpersonal realm, by genetic and/or physiological conditions, by chronic and profound neglect, or by situations that overwhelm the adaptive capacity of the individual. Neurobiological research has established that overwhelming stress, trauma, and neglect particularly impact the parts of the brain that generate thought and memory, often with long term effects, especially in children.

Many children in residential treatment in fact manifest complex traumatic stress reactions that may or may not be linked to a specific experience that can be processed through trauma- specific interventions. Rather they have been "hard wired" in their childhood by the overwhelming stress they have experienced and display chronic and long-term reactions, including faulty and ineffective control

methods (e.g. over-control, self-blame, addictive behavior, self-harm), and impaired attachments (e.g. interpersonal skill deficits, inability to develop resilience). These children's abilities to use cognitive processes or draw accurately upon memory is limited as a result of their traumatic experiences. A wide variety of external stimuli can function as triggers, causing them to respond as if the overwhelming stress or trauma is occurring at the present moment, rather than to what is actually taking place. Their behavior can be wildly unpredictable in response to basic expectations or seemingly innocuous stimuli. They need comprehensive, carefully crafted, trauma-informed surroundings and approaches. The same holds true for their families, which throughout this document can be considered to include siblings.

Trauma-informed care is an approach to organizing treatment that integrates an understanding of the impact and consequences of trauma into all clinical interventions as well as all aspects of organizational function. A core concept of trauma-informed care is a universal precaution:

> ***Presume that every person in the treatment setting has likely been exposed to abuse, neglect, persistently overwhelming stress or other traumatic experiences*.**

This is particularly critical in residential treatment, where the mere fact of being placed is reflective of a loss of one's control over their experience in the world and therefore traumatic.
Trauma-informed settings have some key characteristics:

- Staff understand the short and long-term impacts of trauma and of neglect.
- Staff are trained to respond to the youth, including family members, with empathy, sensitivity, and respect.
- Environments and processes are designed to be collaborative and supportive, as opposed to controlling.
- Coercive interventions and interactions are recognized to be re-traumatizing and to recapitulate victimization, and are therefore contra- indicated.
- The child and family are viewed as individuals who are surviving traumatic stress and their perspectives are the focus of treatment efforts.
- Staff are attuned to the phenomenon of triggers and traumatic reenactments, taking this dynamic into consideration at all levels of the organization.

<u>Organizational Leadership</u>
Treatment organizations, especially children's residential centers, and the staff who work in them, are themselves subjected to overwhelming stress. This is related to the vicarious traumatization that may occur from working with children who have experienced severe and persistent stress, as well as to demands from within the organization and externally that can result in staff feeling hopeless, blamed, helpless, and fearful. If staff are to respond to children and their families with trauma-informed sensitivity, it is incumbent upon leadership to set the stage organizationally by adopting the universal trauma-informed perspective, inclusive of staff.

Embracing the universal precaution to create a trauma-informed treatment entity is challenging.
Nonetheless there are several steps leaders can take:

- Implement shared governance and collaborative decision making. Staff who are actively engaged in decision-making processes that affect the work they directly perform will experience influence over the activities of the organization and derive a sense of personal control over their immediate jobs.
- Adopt a treatment philosophy focused on: relationships; helping children and their families maintain calm engaged states; preventing discontinuous states by maintaining continuity of expectations and supports; and allowing choices.

- Engage Board and staff in developing, revising, or affirming organizational values that focus on inclusivity, collaboration, and empathy.
- Provide ongoing and repetitive training regarding: the cause and impact of traumatic stress on children and their families; the reality that children's behavior is likely an outgrowth of traumatic experiences and not a manipulative attempt to "get their own way"; and specific treatment interventions and or models that are trauma-informed.
- Ensure that treatment is family-driven, youth-guided, and culturally and linguistically competent.
- Neutralize power differentials by including family- and peer-support specialists as equal members and advocates on governing bodies, quality improvement committees, and treatment teams.
- Adopt and create the mindset that it is critical to listen and understand the child's perspective, and to work collaboratively to resolve differences in planning and programming.
- Adjust organizational structures and business practices to promote hospitality and sensitivity, and recognize that organizational environments and cultures impact youth and family engagement and responsivity.

Physical and Interpersonal Environment

Physical environments of residential treatment facilities are powerful conveyors of symbolic and concrete messages. Surroundings that are warm and inviting, comfortably appointed, and adorned with age, developmentally, and culturally appropriate accoutrements convey a sense of belonging and worth to the inhabitants. This includes the living environment and offices, waiting rooms, and general areas. It is critical to give careful consideration to details such as locks and barriers that can convey messages of power and control as opposed to openness, weighing carefully the child's need for a feeling of safety and security. Routine maintenance and immediate repair of damage helps ensure that the physical environment does not contain unnecessary triggers. Involving staff and youth in regular re-examinations of the physical surroundings and design of refurbishments helps keep the milieu fresh and attuned.

Specific physical plant features and activities can promote trauma-informed services. Creating sensory modulation and comfort rooms can provide opportunity for youth to learn self-soothing in the face of emotional dysregulation. Regular walk-through assessments of the environment by staff and youth can reduce factors that may contribute to stress and create settings that enhance emotional processing interventions.

The interpersonal environment is equally critical. It is important that staff adopt the language of collaboration and do not see themselves as agents of control. A trauma-informed mindset assumes that: "bad behavior" is a result of unmet needs; in fact there is "no such thing as a bad child"; children and youth are doing the best they can; and if they are not doing well there is a reason related to how well they are able to think about and process their immediate circumstances. When this philosophy pervades the interpersonal environment, coercive interventions and power struggles are reduced. Instead efforts are made to accommodate immediate circumstances without compromising fundamental routines and structures, which themselves are examined and re-examined by staff in collaboration with the youth. Reminding staff to explicitly discuss and identify routines and expectations proactively helps the children and youth develop and internalize self-regulatory skills. Similarly, anticipating as opposed to reacting to behavior helps staff and youth alike enhance their sense of personal responsibility and self-control. Utilizing person first language and descriptions of behavior that are not pejorative minimizes the potential of re-traumatization.

Programming

Several key programmatic elements come together to create trauma-informed environments:

- ✓ Establish expectations that staff proactively attend to elements of milieu routine that are generally known as triggers, including bedtime, room checks, yelling, close physical proximity, time spent at home or in the community, school, and bus or van rides. Additionally draw staff attention to specific individual circumstances that can often be triggers, such as large men, aggression of any form, and family/peer rejection. Teach staff interventions that help children identify and learn how to manage potential triggers.
- ✓ Teach staff to identify early warning signs and physical precursors of distress that can signal upset or impending crisis. While some may not be observable, others are, e.g. restlessness, agitation, pacing, shortness of breath, described sensation of tightness in the chest, sweating, etc. Sensitive and empathic emotional first aid at such times will often avert power struggles and behavioral escalations, creating spaces for interactions that help the child learn to recognize the stress and self-soothe.
- ✓ Implement sensory integration and sensory modulation opportunities. Work with an occupational therapist to design specific sensory integration/modulation activities and promote exercise, yoga, and other physical activities. These have the affect of reducing stress and enhancing the possibility of cortical activity, i.e. thinking.
- ✓ Eliminate point and level systems, which by their nature re-enact the experience of the child having to "work" external systems to gain even an illusion of control over his/her life, and are most difficult for the most seriously traumatized children.
- ✓ Incorporate expressive therapies, focusing on art and music, to enhance thinking skills in general and to foster the potential to process traumatic memory.
- ✓ Focus programming on activities and interventions that promote thinking skills by asking children and youth to think through situations and make choices, and also by reminding them of something they reported thinking previously while asking them to connect it to what they are thinking or feeling now.
- ✓ Develop and sustain a rich variety of opportunities for children and youth to be active and to learn by doing. Activities are critical in helping children and youth develop a positive sense of control over their own experience that can generalize to other circumstances. Make activities an explicit cornerstone of treatment rather than simply a recreational privilege. Develop practices through which activities are not simply restricted based on behavior but rather can be adjusted based on immediate circumstances and potential safety considerations.
- ✓ Assure that programming creates opportunity for relationship development and teach staff to use programming to develop appropriate therapeutic relationships, while still supporting and encouraging healthy relationships with family and community peers.
- ✓ Involve parents and family members in activities to the greatest extent possible and appropriate to expand family skill building opportunities; respond to the trauma for the family associated with extended separation by programming opportunities for connectivity.
- ✓ Implement wraparound principles and planning processes within residential and link residential services with community-based services and supports.
- ✓ Focus explicitly on skill building throughout all programming, helping children identify skills they are developing.
- ✓ Adopt initiatives to reduce and ultimately eliminate seclusion and restraint, two interventions found to be the most traumatizing for youth, and staff, by integrating strategies identified in this paper (as well as in previous papers in this series).
- ✓ Promote trauma-informed practices with system partners.

Individualized Planning and Intervention

Readiness to do individual trauma work is compromised for children in residential treatment by their developmental age and the nature of the complex traumatic stress from which they often are suffering, Additionally it is difficult to do individual trauma work in situations, such as residential treatment, in which relationships and supports with family and friends are not optimally available. It is nonetheless important to develop and implement individualized trauma-informed response plans. Key considerations include:

- Choose from a variety of trauma-informed and evidence supported practices and approaches, including but not limited to Dialectical Behavioral Therapy (DBT), Collaborative Problem Solving (CPS), Motivational Interviewing, Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), and others, for individual work.
- Allow appropriate degrees of self-determination in how and when individual work occurs, including: not limiting therapy to office settings; utilizing moment-in-time opportunities; training milieu staff to work on specific treatment objectives with the youth; and helping all staff develop a solid understanding of therapeutic relationships and boundaries within their specific roles.
- Develop a fully individualized assessment of each child and their family, based on an understanding of their history of overwhelming stress and trauma.
- Develop systems through which staff may be reminded to implement this understanding in their interventions with each individual child.
- Develop plans that are explicit in identifying cognitive, emotional, behavioral, coping, self-soothing, and social skills that staff support the youth and family in learning about and using at home and in the community.
- Develop an emotional and behavioral support and safety plan for each child/youth that is tailored to that individual's needs, is developed in partnership between the staff, family, and youth, and is written in language that is easy to understand.
- Support the youth and families in identifying youth-chosen individual-specific calming/soothing mechanisms that the youth can use to manage or minimize stress, such as time away from a stressful situation, going for a walk, working out, talking to a peer, laying down, listening to peaceful music, etc.

Conclusion

Many residential treatment facilities have implemented, to varying degrees, much of what is identified above. Nonetheless it is only in the past several years that greater specificity regarding the neuro-sequential development of the brain and neuro-regulatory mechanisms has been available, affording residential treatment organizations the opportunity to become both more comprehensive and more precise in being trauma-informed. And it is clear that many residential treatment facilities have used and still use behavioral approaches that rely upon external locus of control and coercive types of interventions, up to and including restraint and seclusion, which are retraumatizing.

The potential provisions and actions identified in this paper are a cross-section of trauma-informed approaches; significant additional information is available from a variety of existing resources. A primary resource used in this paper is the National Association of State Mental Health Program Directors (www.nasmhpd.org). The National Building Bridges Initiative (www.building bridges4youth.org) is another excellent resource for trauma-informed treatment practices as relates to residential treatment. Both sites identify other resources as well.

AACRC urges its members and residential treatment centers throughout the country and internationally to undertake critical self-assessments regarding the degree to which they are trauma-informed, and to take steps to fully and systemically implement trauma-informed care in their organization. In doing so they will improve outcomes while further enhancing the positive impact most programs already have on the lives of children and families. For further questions, please contact AACRC at (877) 332-2272 or visit the website at www.aacrc-dc.org.

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