



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

This is the eighth in a series of papers by the Association of Children's Residential Centers (ACRC) 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. ACRC 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.

Organizational Leadership

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 responsiveness.

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.buildingbridges4youth.org) is another excellent resource for trauma-informed treatment practices as relates to residential treatment. Both sites identify other resources as well.

ACRC 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 ACRC at (877) 332-2272 or visit the website at www.togetherthevoice.org.