BUILDING RESILIENCE THROUGH RESIDENTIAL COMMUNITIES

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NCTSN
The National Child Traumatic Stress Network

JRI

Trauma Informed Care (TIC) in Residential

- Upwards of 90% of youth in residential or group home settings have experienced trauma[1,2].
- On average, youth in residential are exposed to over 5 different types of trauma before entering care[1,2].
- Due to wide variability in practices, therapeutic approaches, and measurement strategies, it is difficult to determine if residential treatment "works", but trauma informed approaches show promising outcomes [3].

1. Briggs, Greeson, Layne, Fairbank, Knoverek, & Pynoos. (2012). Trauma exposure, psychosocial functioning, and treatment needs of youth in residential are: Preliminary findings from the NCTSN core data set. *Journal of Child & Adolescent Trauma.*
2. Hodgdon, Lord, Suvak, Martin, Briggs, & Beserra. (2023). Predictors of symptom severity and change among youth in trauma-informed residential care. *Child Abuse & Neglect.*
3. Lanier, Jensen, Bryant, Chung, Rose, Smith, & Lackmann, (2020). A systematic review of the effectiveness of children's behavioral health interventions in psychiatric residential treatment facilities. *Children and Youth Services Review.*

What is TIC anyway?

"An organizational change strategy which aligns service delivery with treatment principles and discrete interventions designed to reduce rates of retraumatization through responsive and non-coercive staff-client interactions." [4]

Five key elements:[4]

1) prioritization of TIC by senior leadership,

2) support of staff through training, coaching, debriefing and self-care,

3) collaboration with clients and families,

4) use of data to inform process, and

5) aligning program policies and practices with TIC principles and approaches.

Implementation of TIC, including systems and group-level approaches, in residential settings is associated with increased youth functioning, and decreases in length of stay, rates of restraint and seclusion, and severity of posttraumatic stress [3,5].

4. Bryson, Gauvin, Jamieson. *et al.* (2017). What are effective strategies for implementing trauma-informed care in youth inpatient psychiatric and residential treatment settings? A realist systematic review. *Int J Ment Health Syst*.

5. Boel-Studt (2017). A quasi-experimental study of trauma-informed psychiatric residential treatment for children and adolescents. *Research on Social Work Practice.*

BRTRC: The Broad Strokes

- 5 year grant to support dissemination of trauma informed care (TIC) in residential treatment centers (RTCs).
  - BRTRC Goals:
  1. Wide scale dissemination, implementation and sustainability of effective and comprehensive trauma-informed approaches designed to address the unique needs of RTCs.
  2. Increase access to evidenced based practices (EBPs) for trauma in RTCs serving trauma-impacted youth through intensive training and technical assistance.
  3. Build a trauma-informed workforce in RTCs through education, training and technical assistance via both intensive RTC partnerships and national dissemination activities.

BRTRC Approach

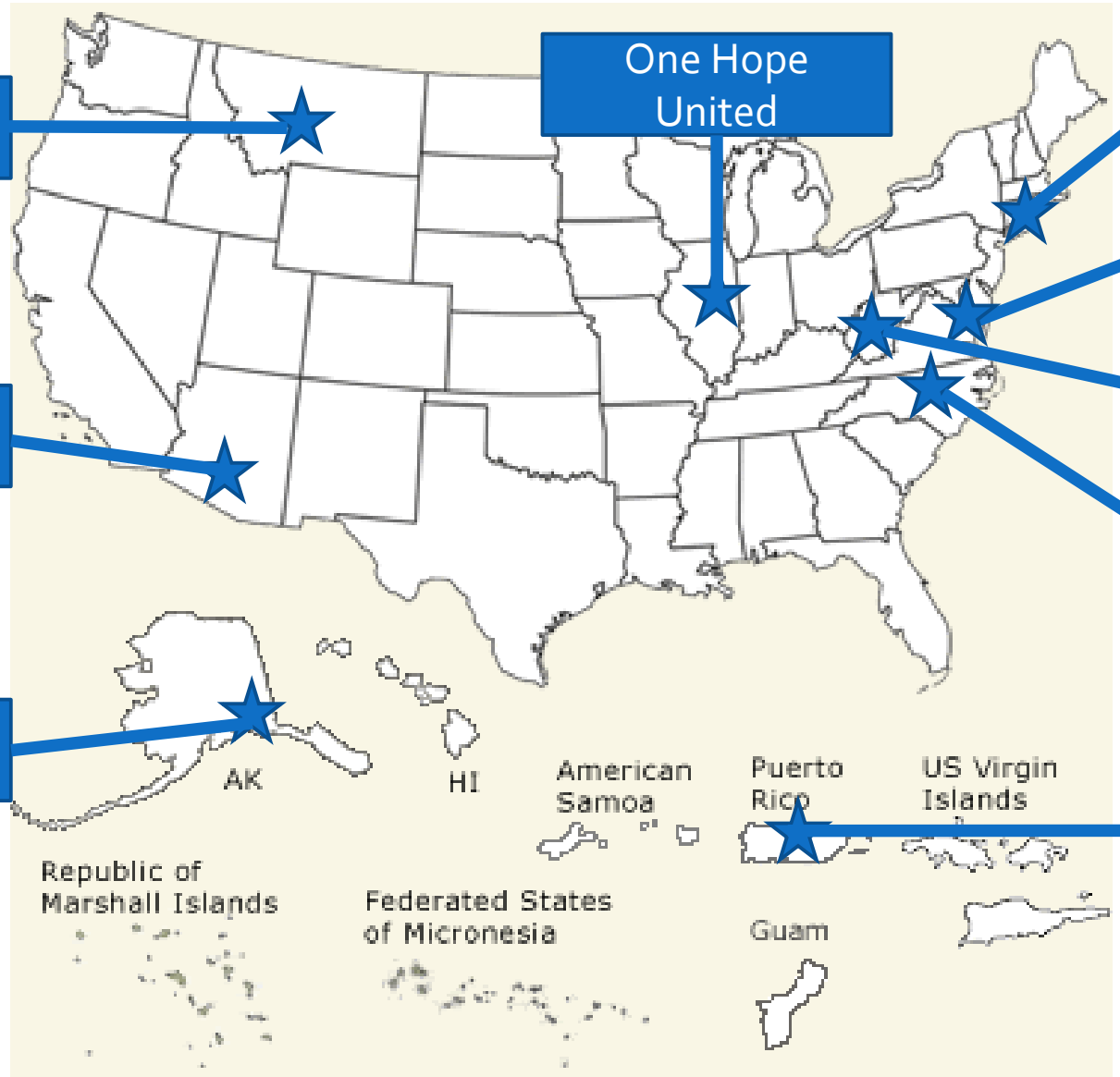
Cohort Model

Participants receive training in:

- Foundational principles and concepts of TIC.
- Building Communities of Care (BCC)[6]
- Psychological First Aid (PFA)
- Trauma Evidence Based Practice for clinical staff:
  - Attachment, Regulation and Competence (ARC).
  - Trauma Focused CBT (TF-CBT).
  - Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS)

- Program Evaluation assessing impact of training on staff attitudes and beliefs about TIC and wellness (secondary traumatic stress symptoms).

BRTRC Partner Programs



Yellowstone Boys & Girls Ranch

Florence Crittenton

Southcentral Foundation

One Hope United

Steven's

Arrow

Crit WV

Youth Unlimited

ASSMCA

Building Communities of Care

Corey Meurer – BCC Director of Operations

Justice Resource Institute

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BCC is…

- Not A Restraint Training Model
- Not A Crisis Intervention Model

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What is BCC?

BCC is a Culture Change

We want to train staff to think about the clients differently, through the lenses of ARC and BCC

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BCC Overview - Development

- Who: Leaders at JRI with various backgrounds (Clinical, Residential, Medical, Educational)
- What: Created, Developed, Implement, and Evolve BCC Curriculum
- When: Created: 2009-2012 (2019 reprint), Implemented at over 20 sites: 2013-2014
- Where: Massachusetts, Rhode Island and Connecticut
- Why: **Mission Statement**: To teach participants to provide trauma-informed, individualized, and strengths-based interventions within a nurturing and supportive community of care.

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BCC Overview - Implementation

HOW:

- In-person, 3 days - 24 hours (Best Practice)
- Virtual, 2 days – 16 hours (3rd day in person – 8 hours)
- Train the Trainer Curriculum – Over 85 trainers within JRI (40 external by 3/2023)
- Site Specific trainings, as well as agency-wide trainings
- External training models
- Supporting 500+ clients daily, not including external trainings/consultation

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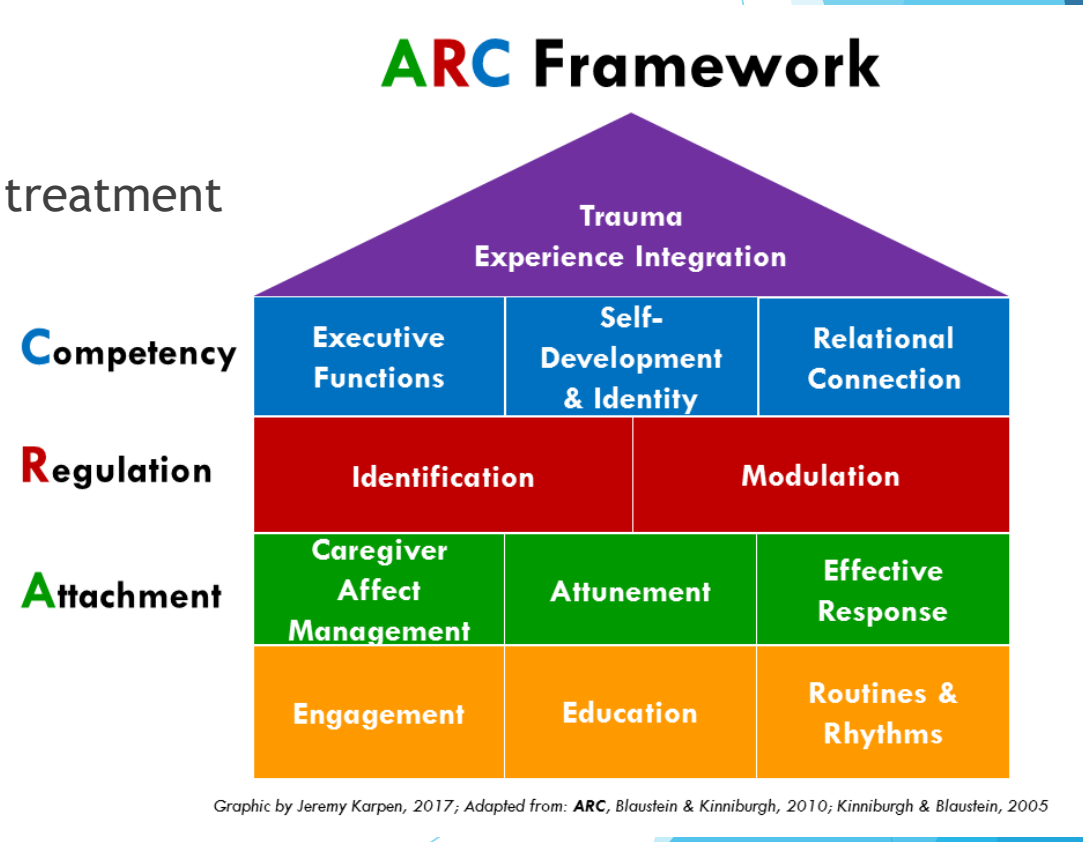
BCC Overview - Curriculum

- ARC-informed Curriculum
- Environment – Safe and Comfortable
- Treatment – Everyone's role and how they impact treatment
- Engagement – Building skills and tolerance
- Interventions – Verbal, Non-Verbal, Physical



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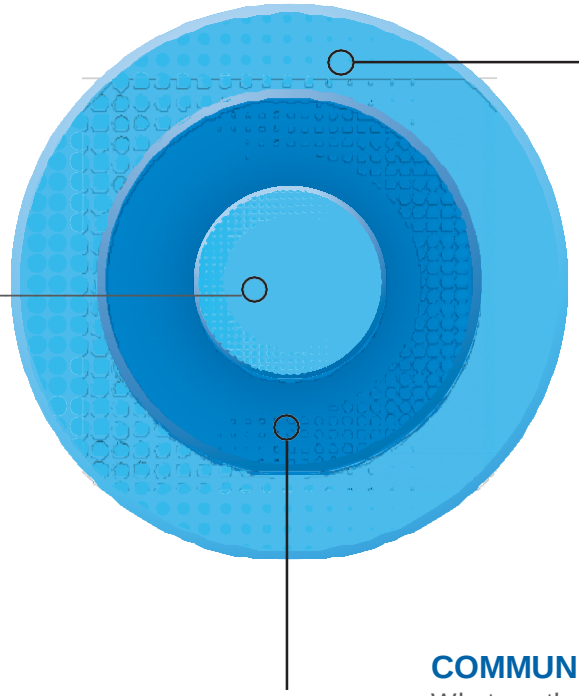
Bullseye Model



EXTERNAL FACTORS
What are the factors outside the setting that can effect the setting's ability to accomplish its Mission?

INDIVIDUAL FACTORS
What are the factors and concepts that can impact the success of the individual?

COMMUNITY FACTORS
What are the factors within the setting that can impact the success of the individual or affect the setting's ability to accomplish its Mission?

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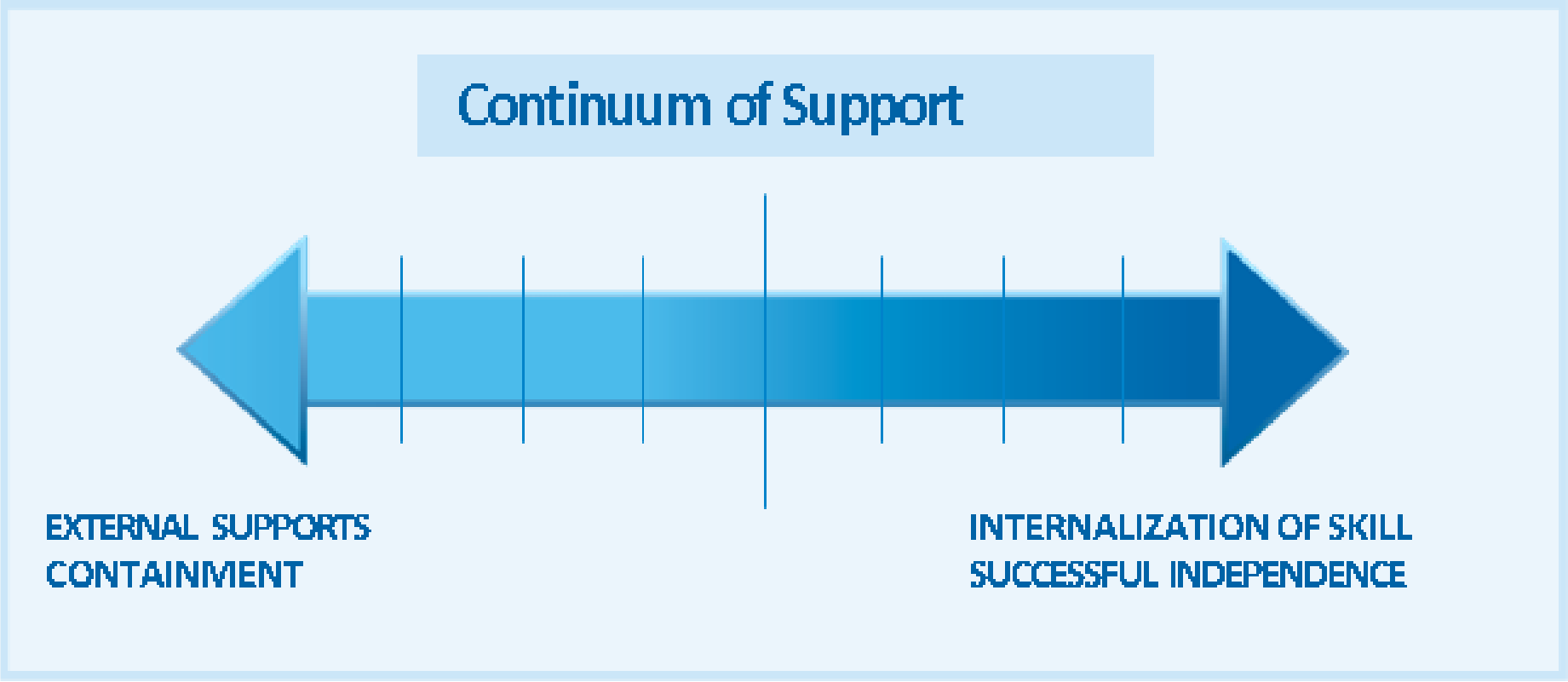
Continuum of Support



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BCC Goals

- The goal of JRI is to establish trauma-informed, therapeutic environments and caregivers. This will provide support for individuals with the goal of eliminating the need for restraint for each individual we serve.
- The processes and systems presented in this training were designed to give each caregiver the tools they need to engage each individual in the most effective manner, supporting each individual's strengths and providing them with the tools they need for a successful and productive life.

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Race, Equity, and Inclusion

Examples:

- Environment

Menu Décor Resources Staffing Language

- Treatment

Expression Religion Medication Holidays Menu

- Engagement

Staffing Training Competency Routines and Rhythms

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Age Group Considerations

Systems-Based Training

- Stage Not Age
- Language (How do we frame?)
- Safety
- Imminent Risk
- Physical Interventions
- Latency Youth – Visual Aids, less words, incentives

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Program Impact on Restraint and Seclusion

Strategies/Interventions:

- Individualized Programming (OT, Therapy, TX Plans, Safety Plans, Discharge Plans)

(Squish Plan, Proactive Breaks, Safe Areas, Sensory Tool Kits, Hygiene Times, Sign Language)

- Weekly Administrative Reviews
- BCC Boosters
- Quarterly BCC Lead Trainer Meetings/BCC Trainer Division Meetings
- Shadowing Hours – In the moment/On the floor Training

Program Impact on Restraint and Seclusion Continued

- Review of Verbal and Non-verbal interventions for de-escalation
- Review of Self-Protection strategies without using restraint
- Agency Wide Boosters with focuses based on data
- Single Person Standing Hold – Trained as emergency hold (Except for latency)
- Since 2014, when BCC was introduced, JRI **Eliminated Seclusion** for all staff-secure JRI Programs

(*Hardware secure settings have own protocols and procedures*)

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The role of staff and caregivers

- Attend, Participate, and be Certified in BCC training and Competencies
- Keep clients safe
- Engage in Daily Living Needs of clients – Build Relationships
- Help recognize and identify triggers/stressors and helpful coping mechanisms
- Teach, model, display tools and techniques to help manage emotions effectively
- Engage with activities designed to help build skills in targeted areas
- Be strengths-based, trauma-informed, and attune to the client's needs

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OUTCOMES

Study of TIC in Residential

548 youth ages 12 to 18 (*M* age = 15.84, *SD* = 1.56) in residential or group home placement trained in Attachment, Regulation, and Competence (ARC) and BCC.

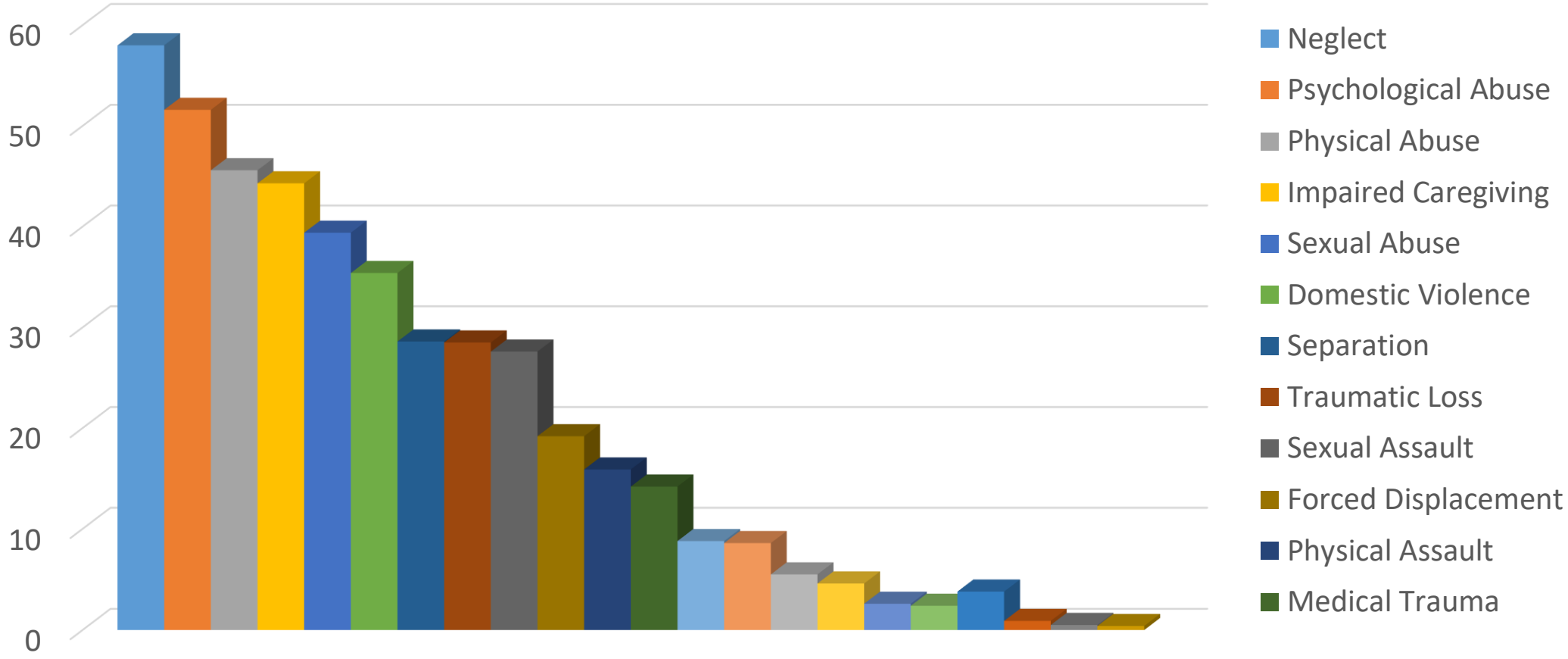
- 56.8% female
- 17.7% Hispanic/Latinx; 48.9% White, 15.3% Black/African-American, 14.6% Biracial/Multiracial, 1.1% Asian
- On average, youth exposed to over 5 types of trauma (*M* = 5.26 [*SD* = 2.6]).

Used Client Assessment Tracking System (CATS) to measure:

- Lifetime exposure to 20 types of trauma (Trauma History Profile)
- Depression (Child Depression Inventory, CDI)
- PTSD (UCLA PTSD Reaction Index for DSM 5)
- Dissociation (Adolescent Dissociative Experiences Scale)
- Dysregulation (Abbreviated Dysregulation Inventory)
- Internalizing & Externalizing (Child Behavior Checklist)

Hodgdon et al., (2023). Predictors of symptom severity and change over time among youth in trauma-informed residential care. *Child Abuse & Neglect.*

Trauma Exposure of Youth: Rate by Type



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Analysis Method

Used Growth Curve Modeling to examine:

- Individual predictors of symptom severity at intake – including age, gender, number of previous placements, and trauma history.
- Change trajectories in clinical outcomes across a 2-year period.

Hodgdon et al., (2023). Predictors of symptom severity and change over time among youth in trauma-informed residential care. *Child Abuse & Neglect.*

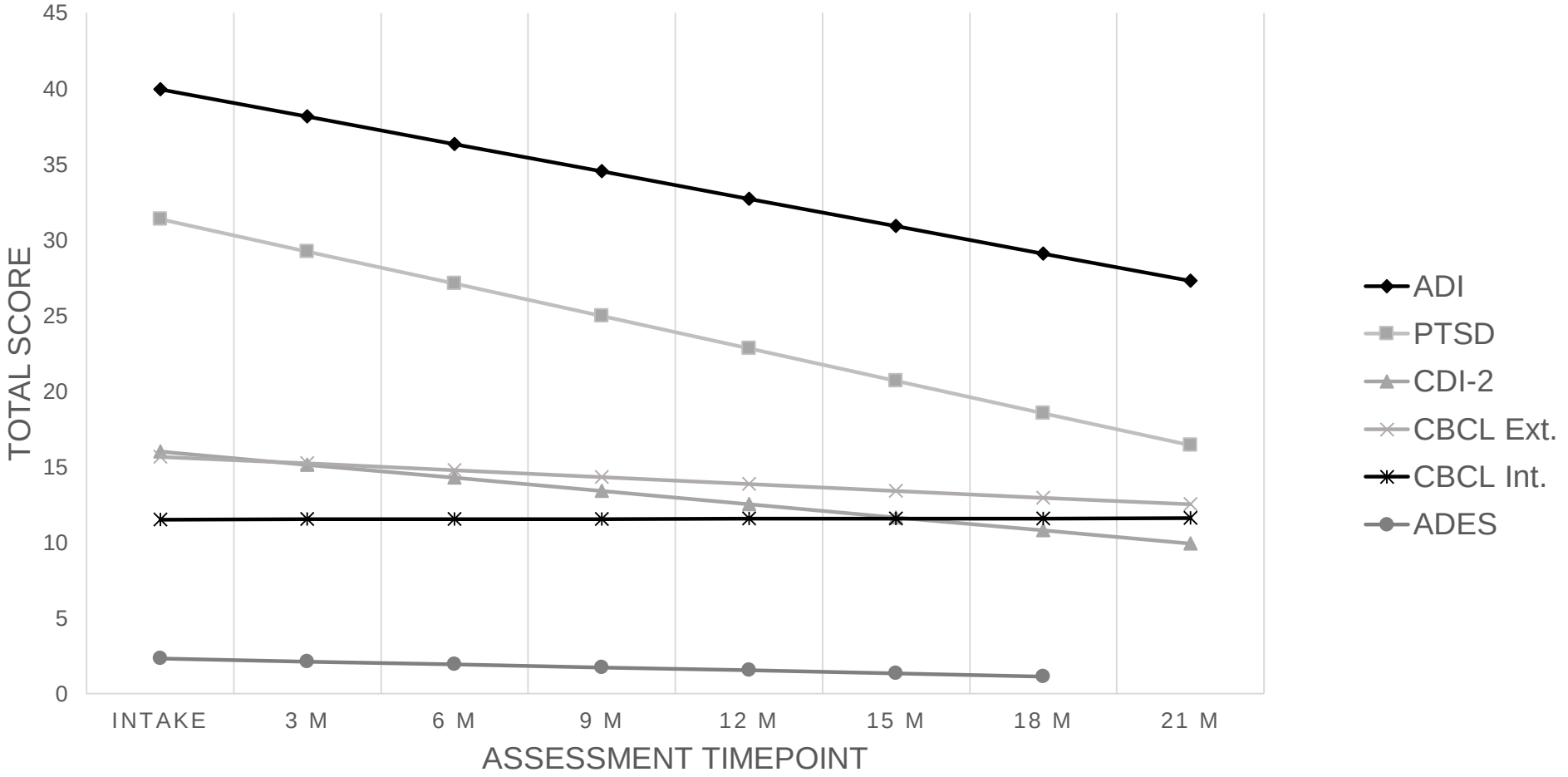
Predictors of Symptoms at Baseline

PTSD	Depression (CDI)	Dysregulation (ADI)	Internalizing (CBCL)	Externalizing (CBCL)
Gender	Gender*	Gender*		
		Age	Age	Age
Cumulative Trauma		Cumulative Trauma	Cumulative Trauma	Cumulative Trauma
		Previous placements		Previous Placements

* Denotes that in addition to predicting baseline symptoms, gender influenced (moderated) treatment response.

Hodgdon et al., (2023). Predictors of symptom severity and change over time among youth in trauma-informed residential care. *Child Abuse & Neglect.*

Change Over Time Overall



Change estimates for severity of clinical indicators from Intake to 21 months of residential treatment, N = 547 youth, ages 12-18 years, receiving ARC and BCC.

ADI = Abbreviated Dysregulation Inventory, PTSD = PTSD-Reaction Inventory, CDI-2 = Child Depression Inventory, CBCL- Ext = CBCL Externalizing, CBCL- Int = CBCL Internalizing, and ADES = Adolescent Dissociative Experiences Scale.

Hodgdon et al., (2023). Predictors of symptom severity and change over time among youth in trauma-informed residential care. *Child Abuse & Neglect.*

Take away points

- Youth in residential have histories of significant and varied forms of trauma.
- The greater the number of trauma types the more severe the clinical symptoms are at baseline.
- However, when TIC is applied, youth with greater exposure to trauma are doing just as well in treatment as youth with less exposure to trauma.
- Overall, youth are demonstrating statistically and clinically significant improvement in symptoms of posttraumatic stress symptoms, dysregulation, dissociation, depression, and externalizing problems.