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The changing role of residential intervention

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ABSTRACT

The role of therapeutic residential care (TRC) is changing. In fact, this article reframes the terminology of TRC and uses "residential interventions" to more accurately reflect that residential programs provide time-limited "intervention" and treatment efforts must connect and extend to families and communities. Such changes are being compelled by necessity and innovation. Necessity is demanding evidence, data, and durable positive outcomes for this expensive intervention. Innovation is transforming basic service delivery through meaningful inclusion of youth and families and effective collaboration with community-based organizations. Service elements that confound this changing role are being reconsidered, including reductions in length of stay, a focus on long-term permanency, and the location of the actual intervention from program-centric practice to interventions in the home and community.

KEYWORDS

Residential intervention; youth; family; role; transformation; permanency

Introduction

"The times they are a-changin'" was a popular 1960s rallying anthem for social reform (Dylan, 1963). It could also have been the forecast for the wave of innovative change coming to "therapeutic residential care" (TRC), the mode of intervention that is broadly defined as group living environments for youth. One example of this change is that this article shifts from TRC and uses "residential interventions" instead to underscore the intent that residential services for youth with serious behavioral and emotional challenges are focused, time-limited treatment and support interventions with the goal of connecting/extending the intervention with youth to their families, homes, and communities.

The long-standing approach to serving children and adolescents (hereinafter referred to as youth) outside of their homes is transforming (Lieberman & Bellonci, 2007). It is being recast, redefined, and reinvented and altering

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this centuries' old approach to substitute care (Building Bridges Initiative [BBI], 2017; Radbill, 1976; Silverman, 2007). Contemporary residentially based programs and their array of services are evolving to further advance youth and family connection and inclusion.

It appears the new generation of residential intervention is responding to the field imperative, "change or die" (American Association of Children's Residential Centers, 2001) and serving an important, necessary role as a short-term way-station to create pragmatic change and help youth and families learn new ways to function effectively together after a brief course of residential intervention – often working directly in the home and community with supportive services continuing after the residential experience. New residential intervention methods are focusing on permanency, home/community connection, and fully integrating youth and family perspectives into all aspects of care. New methods also include implementing new roles for people with lived-experience (e.g., young adult/peer and family advocacy positions) (BBI, 2017; Small, Bellonci, & Ramsey, 2014). Consumer inclusion is extending beyond basic treatment meeting and satisfaction survey participation and changing the fundamentals of residential service. Residential interventions are bringing consumer-driven expertise into the residential experience to ensure relevant, responsive service and bringing residential expertise into the home/community to foster good relational health and effective problem-solving capacity for youth and families. Together, these new shifts in residential service appear to be producing durable positive outcomes post residential intervention (BBI, 2017).

It is important to note that the new conceptual and practice shifts that are described here are not intended to gloss over, minimize, or otherwise skirt the fundamental challenges that accompany delivering residential services or working with youth and families who have experienced trauma and other life-altering difficulties. Nor is this work intended to parse the range of family constellations, the complex needs of youth and families, the array of systemic challenges the field faces, or the resource challenges that every locale experiences. Rather, this work attempts to highlight inspired residential providers who do not shy from organizational self-reflection, making bold change, or the imperative to continually strive to deliver relevant, effective service.

Practices that Confound Effective Residential Intervention and Compel Change

A number of factors of traditional residential service make substantive, sustained change challenging and necessary. These factors include an insufficient evidence base to demonstrate residential intervention effectiveness (James et al., 2015), the physical, social, and emotional disruption

to family and community connections exacerbated by long lengths of stay (Levison-Johnson & Kohomban, 2014), the potential exposure to traumatic experiences resulting in iatrogenic effects (Dodge, Dishion, & Lansford, 2006), and possible "deviancy training" (the unintentional exposure of youth to negative influences through peer associations) (Whittaker et al., 2016). Over and above these essential challenges is the persistent threat of service viability, that is, managing rising costs with limited funding and continual systemic efforts to reduce the use of residential intervention services (Courtney & Iwaniec, 2009; Whittaker et al., 2016). While some factors are outside the scope of control of a residential provider, several challenges can be more effectively managed.

Length of Stay

Length of stay is a significant residential intervention challenge and practice paradox. Residential intervention duration can defy the adage, "more is better." The literature suggests an optimal intervention window of less than 6 months (Lyons, Marinovich, & Hancock, 2009), preferably under 3 months (BBI, 2017; Noftle et al., 2011). Longer lengths of stay can increase the likelihood of additional placements (Heggeness & Davis, 2010). In addition, the number of out-of-home placements is the strongest predictor of longer stays in care (James, Zhang, & Landsverk, 2012). Longer lengths of stay can also increase detachment from youths' home/community connection and directly impact achieving permanency. California's Residentially Based Service (RBS) initiative found the chance of achieving permanency decreased by 84% with each additional residential intervention (Hay & Franz, 2013). Similarly, the chance of achieving permanency decreased by 28% with every additional month beyond the average length of stay in an RBS placement (Hay & Franz, 2013). Another RBS finding: the chance of completing RBS decreased by 15% with every additional month of a youth's stay in placement, based on average length of stay, and the chance of completion decreased by 66% with each additional placement (Hay & Franz, 2013). The RBS data illustrates the "vicious cycle" of residential intervention and how it is reinforced and maintained to the detriment of youths and families achieving permanency.

Several factors that mitigate long lengths of stay have been studied and reported in the literature. Some of the factors include permanency and meaningful family engagement during and after residential intervention (BBI, 2017; Casey Family Programs, 2016; Hair, 2005; Pecora & English, 2016), promoting time at home and in the community (Huefner, Pick, Smith, Stevens, & Mason, 2015), supporting staff and acknowledging persons-served's preferences (Blau, Caldwell, & Lieberman, 2014; Levison-Johnson & Kohomban, 2014), minimizing restraint use (English, 2005),

and attending to worker's perceptions of youth's readiness for transition (Lee, Shaw, Gove, & Hwang, 2010).

Appropriate Use of Residential Intervention

Historically, residential services were criticized for their homogeneity and group-oriented practices. Point and level systems was one of these group practices typically used for behavior management purposes. These compliance systems sidestepped individual needs, taught compliance, and focused on success in the program. These controlling practices did not transfer to the home/community/school (Mohr, Martin, Olson, Pumariega, & Branca, 2009). Functionally, youth were not learning how to succeed and problem-solve independently or with their family. Similarly, family needs were annexed and minimally addressed. Some referred to this practice of isolating family and youth while in care as a "parentectomy" (Voysey, 2012).

Now, residential intervention is shaping care and service to meet the needs of individual youth and families and implementing true "person-centered care" to facilitate meaningful change. With a concerted focus on permanency, providers such as Damar in Indiana recognize the lack of permanency and family connection as key threats to residential intervention success and make these key treatment goals at the start of care (BBI, 2017). Damar considers the lack of daily meaningful connection between a youth and their family as a "critical incident," and tracks it as such. Others, like Sweetser in Maine, plan for immediate connection and engagement at the outset of care and make it the focus of treatment. Families are welcomed anytime. Group activities are minimized to promote youth/family connection and active participation (BBI, 2017).

Youth and Family Advocates' Perspective on Engagement

Engaging youth and families as partners in residential intervention is essential to not only the youth and families, but to the residential program and system as well. Many large businesses and corporations engage their customers to improve their products, services, and their bottom line. Residential providers should be no different. Who better to engage in quality and service improvement than the people who are served?

Engaging families as partners is also important because they are the experts about their children. When families are viewed as partner-experts, the youth and family benefit during and after the intervention. This collaboration can also decrease the feeling of "fault" and "guilt" that parents may feel and can increase the sense of being valued and respected, which enhances receptivity to the services offered.

Engaging families as partners is also important for the youth. To see their families involved and engaged can give youth a sense of reassurance and

comfort and help them participate in and benefit from the services more readily – potentially shortening lengths of stay and reducing recidivism. Engaging families and youths also gives residential staff an unambiguous perspective of the importance and value the organization places on those they serve, which in turn shapes staff's roles and practice accordingly.

Engaging families is not always easy. Like their children, families have often been traumatized and are crisis-conditioned. Family members can sometimes be angry, emotionally reactive, and/or easily triggered. By the time their child has arrived at the residential door, some families are prepared for fight or flight – particularly if staff are not culturally humble, culturally sensitive or trauma-informed. For this reason, residential providers should be prepared to offer more on-boarding support than is generally offered.

Residential providers can engage families in very basic ways: greet them warmly, address them as they introduce themselves (e.g., Ms., Mrs., Mr., etc.), reach out daily, schedule meetings that respect their schedules, be direct, speak clearly, forget the psychobabble, be optimistic and hopeful, keep families informed, seek their opinions, and ask permission. As one parent reminded staff, "Remember: this is my child!" Similarly, families can be engaged by listening to them, responding to questions in a timely manner, incorporating their goals/wishes into treatment, and minimizing elaborate activities/outings that do not include the family/siblings and can't be replicated at home. One parent pleaded with residential staff, "Please listen to me!?" after her child refused to come home for three weeks in a row so she could participate in program activities that were too expensive for the mother to provide for her child.

Peer advocacy is another way of engaging youth and families. Being supported by someone with lived-experience (i.e., family and youth peer partners) can ease their entry into the residential experience and provide special care and attention from someone who has had similar experiences. This commonality can facilitate the development of a trusting relationship more quickly. Peer advocacy can also reduce the social isolation that comes from living through acute crises and pervasive sense of "going it alone." Finding a peer group helps youth and families to create voice/choice, develop self-advocacy skills, and feel more confident in their role during the intervention experience.

Engaging the youth as partners is also important because their involvement provides the opportunity for participation in their own treatment and affirms that what they say matters and their opinions and views are valued. Just as a parent is an expert on their child, youths are experts of themselves. Being recognized as a partner can increase a youth's sense of self-esteem, self-worth, and make them recognize their strengths. Youth often feel as if they are "sent" to a residential program because they are "bad" or "damaged." Being respected as a partner can decrease this negative attribution and can help to motivate youth to

create and follow their own success plan rather than being "told" what they must do or follow a plan they had no role or voice in creating. By listening to them and incorporating their preference into practice, treatment becomes person-centered and relevant. Youth often know what they need and often know what other youth are going through and feeling. Having youth meaningfully participate in their treatment and involving them in decision-making processes helps them to learn to advocate for themselves (and others) in healthier ways and accept the services that are offered.

Youth and family engagement and use of family and youth peer partners also enhance the effectiveness of the residential service. Outcomes are improved through meaningful engagement, e.g., decreased length of stay, decreased recidivism, decreased restraint/seclusion, decreased medication use, and increased youth/family functioning and community tenure (BBI, 2017). At a basic level, youth and family engagement can build a stronger network of support for families and youth receiving residential care and can improve the financial health of the organization. One residential leader reported infusing practices from a short-term pilot project into his longer-term residential services (e.g., parent engagement, parent support, working with families in their homes) and found important fiscal advantages stating, "This past fiscal year was the first year in at least a decade where we did not lose money on the operation of our residential programs" (K. Keegan, personal communication, August 21, 2017).

When youth and families are engaged in residential service as consumers and in professional roles, they can play an active role in transforming their lives and the intervention itself. This type of service shift and engagement is not fast or easy. Major change takes focused leadership, commitment, and creativity to overturn generations of program-centric practices that have often unintentionally excluded the voice and choice of those they served.

Oversight Agency Roles to Support Change

Residential providers can do much to advance the role and practice of residential intervention, but it is difficult to change alone. Oversight agencies and systems (including federal agencies, states, counties, cities, and funders/insurers) have key roles in facilitating the changing role of residential intervention into short-term services with sustained positive outcomes for youth and their families. These agencies have a responsibility to support the desired changes/outcomes by using their resources (fiscal, regulatory, political, etc.) and their leadership to promote transformation. Agency leaders can cast the new vision of residential intervention and disseminate the framework and requirements for change (BBI, 2017). Leaders can also advance best practices, create higher standards, develop opportunities for learning, and set new requirements for funding that are tied to positive outcomes. Additional steps and methods include:

- Declare a new vision, values, and financing models for residential interventions
- Affirm the best place for youth is with family
- Focus treatment on permanency
- Partner with the family prior to, during, and after the residential intervention
- Commit to strength-based, individualized, trauma-informed, culturally and linguistically competent, family-driven, and youth-guided values and practices, and develop oversight mechanisms to hold programs accountable to high standards
- Continually seek new ways to finance services and incentivize positive outcomes
- Fund aftercare services to support the youth and family in the community with the same culturally competent child and family team that supported them during the residential intervention
- Ensure youth/families are served in the communities in which they live
- Ensure youth/families are part of quality oversight of services and service development
- Measure youth/family engagement and measure time spent at home
- Require professional consumers roles in intervention services
- Engage members of the private sector who can advocate for and with the youth and family as partners
- Use a Child and Family Team and Family Team Conferencing as the primary vehicle for collaboration on the assessment, case planning, and placement decisions that are typically made by the placing agencies
- Use data to track and measure outcomes (e.g., readmissions, school/employment)
- Use common assessment tools including strengths and needs
- Guard against long-lengths of stay by addressing contributing risk factors during the intervention (harmful behavior, substance use, etc.)
- Raise standards of practice (regulations, policies, standards)
- Use evidence-informed tools, methods, approaches that respect and support the cultural and linguistic differences of youth and families served
- Require transparency in data sharing/reporting (BBI, 2017).

A Study in Change: Seneca Family of Agencies' History

Seneca Family of Agencies was founded in 1985 as a small residential and day treatment program for some of California's most challenging young people. Several individuals, including the CEO and president, launched the agency in response to what they saw as a great injustice –foster youth with significant mental health and behavioral needs were being moved between foster homes and residential treatment settings, compounding the trauma of disrupted attachments,

inconsistent caregiving, and severed social support networks. This cycle amplified symptoms related to trauma and loss and youth would end up hospitalized or involved in the juvenile justice system. Youth, and those caring for them, were failed by a system that was under-resourced and unable to meet their unique needs. The result of this systemic problem was the marginalization and isolation of these youth and the lost opportunity for these youths to achieve their greatest potential.

Seneca's initial residential program had a simple goal – to provide youth with the compassion, consistency, care, and stability that they needed, regardless of the challenges they faced, so that they could heal and thrive. This founding commitment to stay with children through whatever challenges came their way became known as the agency's practice of "Unconditional Care." With the growth of the program and the addition of new ideas and expertise, this foundational commitment became a fully articulated clinical treatment approach, published as *Unconditional Care: Relationship-Based, Behavioral Intervention with Vulnerable Children and Families* (Sprinson & Berrick, 2010).

Not surprisingly, the early Seneca program with its commitment to ensure youth experienced consistent support and belonging helped youths to develop new skills and experience meaningful improvements in their behaviors and ability to engage positively with others. The unconditional positive regard youth experienced altered years of rejection (rooted in attachment theory), and coupled with a consistent positive behavioral approach (rooted in learning theory), the approach provided youth the context in which they may feel safe and secure with highly attuned adults and begin to address the trauma and loss experienced throughout their childhood.

However, the successes youth experienced within the safety and containment of the residential program often failed to transfer to their homes and communities as they transitioned to new settings. Youth relied on the structure, consistency, and nurturing attachments with staff in the residential program and without that balanced constellation of factors reverted to previous harmful behaviors and unsuccessful coping strategies. Caregivers were not prepared to offer disconfirming responses to provocative behaviors and/or the same intensity of support in the face of such behaviors – a difficult feat even in a controlled milieu environment. What became clear was that a positive, caring experience in the residential program with highly trained and attuned staff, even with the growth that youth experienced while there, was insufficient to prepare them for the permanency, stability, well-being, and belonging they needed.

In response, Seneca's leadership looked to bring the skills and resources that proved successful in the residential setting into community environments through home and school-based services. Together with advocates and state leaders, Seneca helped bring legislation to California that expanded Wraparound using blended mental health and Aid to Families with

Dependent Children funding and Intensive Treatment Foster Care statewide. These efforts were part of what have now been more than 20 years of efforts to reform congregate care in California. Critical to these efforts were the work of legal advocates who worked to expand the use of Early and Periodic Screening, Diagnostic, and Treatment mental health funding to provide new and innovative programs, such as Therapeutic Behavioral Services, to divert youth at risk of residential placement and playing an important role in enhancing the use of blended funding in support of comprehensive programming for foster youth.

This work represented the start of a pivotal shift in Seneca's treatment approach of *Unconditional Care*. The two streams of intervention rooted in attachment theory and learning theory now had the intentional addition of ecological interventions (rooted in systems theory) that looked to enhance and strengthen the intersecting systems – families, schools, and communities – that provided the long-term care, stability, and permanency for these youths. To leverage this blending of attachment, behavioral and ecological systems theories, Seneca embarked on a paradigm shift. At its core, staff and programs needed to shift from seeing themselves as the primary caregivers and the primary attachment figure for youth to becoming the facilitator of repairing and strengthening attachments with permanent caregivers—including those who themselves experienced previous disrupted attachments. This marked an important change in the clinical approach for Seneca. The founding of the agency and the imperative for staff to face serious behaviors with grace and calm was that that agency and staff filled a critical role and provided an experience for youths that few could offer. Re-centering that commitment to trust and focus on other caregivers as the permanent attachment figure and permanent caregiver required a shift in program and individual behavior, and in mindset.

By 1999, Seneca's residential programs were part of a continuum of care, with youth able to transition from Seneca's residential programs into families supported by Wraparound or Intensive Treatment Foster Care services that brought in training, skills, and resources designed to support youth's permanency.

Through the collective efforts of providers and public partners across the state, the number of youth in residential programs decreased. With this change, however, the intensity of the service needs of those remaining in residential programs intensified, yet "typical" residential programming and funding models for residential intervention remained unchanged. Many youths still failed to achieve sustained family placements and residential placements continued to be viewed as long-term options for youth that had experienced profound and multiple losses and placement failures. As a result,

the highest need youths continued to experience many of the poor outcomes of years past.

Launch of Residentially Based Services

With a continuum of services now built to support youth to being diverted from or stepped down from residential treatment programs, stakeholders recognized that a true transformation of how residential interventions were provided was a necessary next step. The development of a continuum of community-based services brought expertise and resources typically offered only in the residential program into homes and families. There was a recognized need to figure out how to best successfully bring families and community in as partners in the delivery of residential services.

State leaders within California and advocates achieved legislation to pilot RBS in four counties, to be evaluated with funding from Casey Family Programs in order to inform statewide reform efforts. Participating counties were tasked with designing innovative program and funding models that improved outcomes, namely the achievement of family placement and permanency, while not increasing the cost to the state for residential treatment. While exact program strategies differed by county, a stakeholder group and subsequent efforts established key practices of the RBS model including:

(1) An early and intense engagement of families.
(2) A focus on therapeutic enhancement of youth well-being and, at the same time, immediately pursuing permanency planning and concurrent planning in case the intended adult cannot be the youth's permanent caregiver.
(3) Family services to help parents improve their parenting knowledge and skills while respecting their cultural norms and expectations.
(4) Post-permanency supports that involve ongoing aftercare services to youth and families.

Seneca Family of Agencies, in collaboration with Edgewood Center and Catholic Charities/St. Vincent's School for Boys, partnered with San Francisco County in their pilot of RBS programming. While not included in the key practices established across all participating counties, San Francisco County and its partners recognized the importance of ensuring the services provided were culturally reflective, responsive, and respectful. At the heart of the redesign of residential intervention was the recognition that families and communities were the drivers in the success of the youth's stability, and full engagement and connection with adults in the youth's life

was critical in that process. Therefore, it was essential to understand the complexity of the needs of youth and families and to leverage the strengths of their individual and familial cultural norms to help them achieve their desired outcomes.

Seneca RBS Implementation

RBS programs had a central focus on family engagement and preparation for transition to a home setting from day one in the program. The need to create and maintain a sense of urgency required that RBS services be most intense at the front-end. Within 2 weeks of placement, RBS staff were expected to have made significant progress in family finding and engagement, employing strategies and practices to discover multiple family members and/or fictive kin (disconnected nuclear family members, extended family and non-relative caregivers/family, including those known and not known to the child) for each youth. During this time, the first child and family team conference was to be held, an individualized needs and strengths assessment completed, and connections with potential satellite providers and informal sources of support made. Multidisciplinary assessments reflected non-biased and culturally relevant factors, stabilizing factors, risk factors, and service gaps in each youth's life were also completed, ensuring that service planning was individualized and targeted to improve a youth's ability to return to family and community.

In contrast with their role in traditional residential treatment, RBS practitioners focused on stabilizing each youth addressing immediate behavioral, attachment and ecological needs and getting them ready to heal at home and in the community, rather than in the impermanent and highly structured environment of the residential milieu. Simply stated, the RBS residential milieu was designed as a stabilization and "readiness" program designed to prepare children and families to heal in their own families and within their own system of natural supports. A key goal of this readiness program was to intervene intensively with each youth and family, building upon their sense of hopefulness during the early part of placement, offering relational responses and attunement that would facilitate changes in their attitudes and behaviors. Supporting children and families when they were doing well provided momentum to increase the pace of transition and motivated them to utilize natural and formal community supports. In many cases, the initial, intensive treatment focused on reducing the effects of trauma through empirically tested interventions, such as Trauma-Focused Cognitive Behavioral Therapy and Motivational Interviewing and effective supervision of staff. At the

same time, RBS staff supported family members to gain and strengthen confidence and competence to successfully welcome their children back home. To further enhance the available resources for families, Seneca formed partnerships with Family Support Organizations to have parent partners as part of the team to support families with reintegration and stabilization in the community.

The RBS residential milieu was re-envisioned and restructured to promote short lengths of stay for each young person. RBS was designed to be flexible, individualized, and as home-like as possible – welcoming and incorporating family members (family being defined as broadly as can be imagined) at any time, day or evening. For example, a grandmother might come to read a bedtime story to her grandson to help him go to sleep at night and those identified as family (e.g., mentor, teacher, previous staff, neighbor, close friend, etc.) were welcome to have meals at the RBS program. If family members believed that the milieu behavioral system was not a good fit for their child, then RBS staff worked with them to develop alternative interventions to support his/her behavior. Within the milieu and in the community, staff facilitated a peer culture that helped each youth's progress toward community reintegration. Staff celebrated the individual interests and talents of each youth by ensuring positive, strengths-enhancing activities such as organized sports or music and dance performances that matched their talents and interests both within the program and with prosocial peers in the community.

Creating and maintaining a sense of urgency for permanency meant that discharge planning and implementation of parallel community services (both by RBS family services staff and by residential-based staff who may have weekly flex-time to provide community interventions) began as soon as a child enrolled. Child and family teams met regularly and frequently (weekly during the early stages of placement). Child and family team meetings were held at the RBS residential program, in family homes, or other community settings at the times and locations most comfortable to the family in order to accelerate the young person's transition to family and community living.

The parallel, pre-discharge and post-discharge community services implemented closely followed wraparound philosophy, with RBS family services staff intervening more frequently and intensively at the beginning of the process, followed by the increasing transition of each youth and family to supports provided by satellite agencies and other formal and informal resources in the community. Family members, with the support of RBS staff, were the drivers of the service planning process for their child. Therapeutic behavioral services and mobile crisis response were available to each youth and family in order to stabilize and support

Traditional residential placement	Residentially based services (RBS)
Long-term placement intended to provide a stable, protective home for youth to grow up in	Short-term service that integrates milieu, school, and community-based interventions to stabilize and transition youth to community settings
Interventions targeted at changing the youth's behaviors and needs	Interventions supporting youth's improved safety coupled with equal focus on strengthening the family and community intended to provide their long-term care
Staff serve as fictive family and "protectors" of youth in placement	Wide net is cast to locate and engage family (e.g., through family finding) and build lasting relationships
Systems and services work in isolation	Services are integrated both vertically (across levels of intensity) and horizontally (across sectors)
A general milieu-based behavioral intervention program is applied to all youth	The program is highly individualized with behavioral, attachment-based, emotional support plans adapted to youth that addresses the most pressing challenges to their safety and permanency in a community setting
Identification of potential placements and preparation for youth's transition begins when they show improved behavior that indicates readiness for living in a community setting	Planning begins day one in the identification and engagement of potential long-term families, with identified potential caregivers serving as partners throughout the treatment and support process
Training and preparation for staff is focused on intensive and robust intervention with youth, working primarily on youth engagement and intervention in the milieu and little attention to family engagement	Training and preparation for staff is focused on building strong engagement with families – including families with complex needs, and all systems and supports, ensuring that transition to permanency and stability is central in all treatment planning and intervention approaches
Professional-driven treatment process and plan	Child and Family Team-driven treatment planning process

their progress at home, in school, or in other community settings. Prosocial opportunities that enhanced the youth's individual strengths and interests were identified in the community to ensure those activities were sustained.

Transformation in Practice and Philosophy

With the RBS model development and other state efforts came core areas of transformation in both practice and philosophy.

Next Steps in the Ongoing Transformation of Congregate Care

As a result of the lessons learned from RBS implementation and the ongoing leadership of public and private stakeholders, new efforts are underway: California's Congregate Care Reform and the recent launch of Short-Term Therapeutic Residential Placements (STRTPs). STRTPs are funded through blended Medicaid and Aid to Families with Dependent Children dollars (now referred to Temporary Assistance for Needy Families) at significantly higher rates than previous group home rates.

With these resources are more stringent expectations about who is eligible for congregate placement and a requirement to provide intensive specialty mental health services as part of programming. Services must be designed to be short term with an intended duration of 6 months or less, and special authorization needed for longer-term placement. To achieve this goal, STRTPs must have a robust plan in place for addressing permanency planning for each youth, they must engage in no less than monthly assessment and planning to address youth's needs, and must provide for ample opportunities to have meaningful engagement with their family, friends, and community. While not part of the mandates of STRTP, in its implementation Seneca adopted some unique and exceptional enhancements, e.g., Youth Advisory Boards and Caregiver Advisory Boards to ensure that youth and family voice is both represented in decision-making and program modifications, and highly resourced milieus in which no more than four youth may be placed at a time with no fewer than four staff during waking hours. Expectations for the qualifications and training of staff have increased with the new STRTP regulations and a strong focus has been put on the needs of some of the most marginalized youth including Commercially Sexually Exploited Children, LGBTQ youth, and non-minor dependents. STRTPs must engage in ongoing performance improvement efforts to improve their practices and must be nationally accredited. The first STRTPs are just now opening in the state, many evolving out of existing group home placements. Seneca was the first organization to receive the STRTP license designation and has opened two STRTP-licensed facilities, with another one forthcoming, each with a unique focus designed to meet the needs of the county and population served.

While the outcomes of Seneca's STRTP programs are limited due to its infancy, initial outcomes show promising stabilization and permanency outcomes with recidivism to Seneca's STRTPs remaining at 0% at the time of this writing. Indeed, the work of the Congregate Care Reform group and the subsequent launch of STRTP statewide is a culmination of more than 20 years of efforts by providers and advocates across the state to better meet the needs of the most challenging youth in the state.

On the horizon, Seneca plans to seek new opportunities to innovate and creatively solve the complex needs of the youth and families served. The organization expects to continue to grow and expand the array of services offered. Equally important, Seneca will continually strive to improve the services provided.

Summary/Recommended Next Steps

Residential interventions are changing. Many providers, some referenced here, are braving new ground and leading innovation. But this effort is new. More evidence is needed.

As more data becomes available to evaluate these services and their outcomes and the needs of youth and families are continually reviewed and measured, the service delivery system will likely continue to shift toward an integrated approach that connects residential intervention to services for youths/families in their homes and communities. Brick and mortar programs will/are no longer the only setting for "therapeutic residential care." Residential services will extend beyond a specific location and move to evidence-informed and -based treatments that produce durable positive effects post intervention.

Youth and family functioning post-discharge is key. To justify the emotional and financial costs of placing a youth in a residential program, funders and regulators will continue to ask about a "return on investment," which translates into long-term sustained positive outcomes after discharge. This means that successful residential interventions will continue to change and transform their service approach by reducing lengths of stay; creating a welcoming atmosphere with genuine partnership with youth and families; supporting youth and families in homes and communities during and post-discharge; collaborating with schools and community agencies; assisting in crisis and post-discharge support; and ensuring that the needs, wishes, and perspectives of youth and families are at the center of all interventions (BBI, 2017).

Successful residential programs will engage youth and families as the arbiters of quality and the "compass of care," and understand that the skills that are developed during a residential intervention must be able to transfer to the home and community. Successful programs will also find new ways to include youth and families in the overall structure of the agency. This includes having youth and family members on the agency's board of directors, hiring youth and family members as part of the agency workforce, including youth and families in hiring and policy decisions, and partnering with youth and family members when conducting training and quality improvement activities (BBI, 2017).

Transformation of residential services also includes additional research to inform the ongoing evolution of the industry. For residential services to remain viable there must be evidence about treatment effectiveness and service efficacy. No longer can a program rest on the idea that residential intervention by itself works without producing generalizable results. The future of residential intervention requires evidence.

The good news is that there are an increasing number of residential providers that are making these fundamental changes. The number of agencies and

national organizations that support the Building Bridges Initiative (BBI) (www.buildingbridges4youth.org) is one example. As funders and oversight agencies become more sophisticated and use data to inform service contracting and provision, the field is likely to see more performance-based contracting (i.e., pay for performance), new legislation and regulations that require programs to collect and provide data, and new performance standards that reflect the types of practices described in this work and this special issue. Those organizations that embrace change will likely thrive, and the outcomes for youth and families that experience these changes will likely demonstrate positive effects as well.

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