

Building Bridges Initiative:

The Building Bridges Initiative (BBI) is a coordinated national effort to identify and promote best practice and policy that will create strong and closely coordinated partnerships and collaborations between families, youth, advocates, community and residential service providers, and oversight agencies. The overall goal of BBI is for families and youth who receive a residential intervention to realize sustained positive outcomes post-residential discharge, including outcomes such as decreased readmissions to congregate care, improved family relationships and home stability, and successful living in the community.

BBI emerged out of national meetings of family members, youth, residential providers, advocates, and oversight agency representatives. It is guided by a Joint Resolution with signatories from across the country. Led initially by a multidisciplinary Steering Committee, the initiative is now given direction by a non-profit organization under the leadership of an Executive Director, small staff, and team of expert consultants. It provides training, coaching, consultation, and technical assistance to state and local jurisdictions, individual organizations, and quality improvement collaboratives.

BBI Framework:

The BBI Framework consists of five Core Principles and a detailed matrix of Performance Guidelines and Indicators that identify specific practices that implement them.

The Core Principles, presented graphically showing the interrelatedness, are: Family Driven/Youth Guided, Cultural and Linguistic Competence, Clinical Excellence and Quality Standards, Accessibility and Community Involvement, Transition Planning and Services. It may be found on the website, at: <http://www.buildingbridges4youth.org/technical-assistance>.

The Performance Guidelines and Indicators Matrix specifies practices that implement the Core Principles. It is organized to enable self-assessment against these indicators using the Self-Assessment Tool. It may be found on the website at:

http://www.buildingbridges4youth.org/sites/default/files/Building%20Bridges%20Matrix%20Final%20for%20web_0_0.p df

The Spanish version of the Performance Guidelines and Indicators may be found on the website at:

http://www.buildingbridges4youth.org/sites/default/files/6_BBI_Performance_Guidelines_and_Indicators_Matrix_-_Performance_Guidelines_and_Indicators_Matrix_0_0.pdf

Child and Family Team (CFT):

A team of people that includes, at a minimum, the child or youth and his/her family, a social worker or therapist, and any other important people who are identified and invited by the child/youth and family to participate in planning. This may include teachers, extended family members, friends, family support partners, healthcare providers, coaches, community resource providers, representatives from faith-based organizations, representatives from other service systems like child welfare, developmental disabilities, or juvenile justice, etc. If a youth is American Indian, then the appropriate tribal representatives should also be included. The team develops a service plan for the child/youth and coordinates care. Family members and youth should play

a central role on the child and family team. The size, scope and intensity of team member involvement are determined by (1) objectives established for the child; (2) needs and wishes of the family in providing for the child; and (3) which individuals are needed to develop an effective service plan. The CFT is ideally composed of 51% family members and their natural supports. It can expand and contract as necessary to be successful on behalf of the child. Ideally, there would be some continuity in team membership over-time regardless of where the youth is receiving services. For the Qualified Residential Treatment Programs under the federal Family First Prevention Services Act legislation this might be called the family and youth permanency team.

Child and Youth:

These terms are used interchangeably to refer to children, youth, and young adults ages birth to 24.

Community System of Care:

A community system in the context of this tool refers to a subset of the larger system of care defined below in this glossary. That subset would include residential programs and community-based providers, schools, public systems, Tribal governments and Tribal organizations, family organizations, Parent/Youth Peer Partners, physicians, and in general all of the community-based services providers (of all types, formal and informal) who play a role during any phase of a child's involvement in the residential intervention (before, during, following).

Community Resources:

Services, supports, and relationships that a youth and family need to thrive in the community, including, but not limited to: immediate family relationships, other supportive relationships [*e.g., relative(s) and non-relative adult(s) and peer(s)*], non-residential clinical services providers (*e.g., psychiatric, counseling, crisis intervention, etc.*), other formal service providers (*e.g., medical, social services, probation, community-based education, etc.*), recreational affiliations, transportation for the youth and family, housing, faith-based affiliations, job training, employment, financial resources for the child and family.

Culture:

A system of collectively held values, beliefs, and practices of a group which guides decisions and actions in patterned and recurrent ways. Systems refers to organizations, groups of organizations, youth and families. Central to family driven care is the recognition that every family has its own distinct family culture defined by the family, not the provider or others in the system. For example, *e.g.*, some families are loud and chaotic, others are religious, or use a shaman etc. This is also applicable and central to cultural and linguistic competence as applies to cultural groups, defined below.

Culturally Appropriate and Responsive:

Services and supports that are attuned and responsive to the unique cultural strengths and needs of the child and family in the context of the distinct family culture, as defined by the child and family. This would also include services that have been normed with the family's particular ethnic group or have been culturally adapted for them.

Cultural Competence:

The ability to work well with people of any culture and to embrace culture as a strength in treatment. More broadly, cultural competence is a process of learning that leads to an ability to effectively respond to the challenges and opportunities posed by the presence of cultural diversity in a defined social system. The principal standard for an organization is to provide effective, equitable, understandable and respectful quality

care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy and other communication needs. Cultural competence requires that organizations have a defined set of values and principles, and demonstrate behaviors, attitude, policies and structures that enable them to work effectively cross-culturally. They should also have the capacity to: (1) value diversity, equity, and inclusion; (2) conduct self-assessment; (3) manage the dynamics of difference; (4) acquire and institutionalize cultural knowledge; and (5) adapt to the diversity and cultural contexts of the individuals, families and communities they serve. All aspects of cultural competence should be incorporated in policy making, administration, practice, service delivery and systematically involve consumers, families, and communities.

Family:

Broadly defined as any member of the youth's biological, adoptive/customary adoptive or foster family, legal guardians, or any other person who plays an important role in the youth's life *which would include relatives (such as siblings, grandparents, extended family, Tribal members) and non-related kin (often referred to as fictive kin) and who is identified by the youth as "family"*.

There are multiple dimensions of family to be considered related to permanency for the youth:

- *the "family" that would need to be involved as part of maintaining permanent connections, and*
- *the "family" that would need to be involved to achieve a permanent living situation that is an enduring "family" relationship that:*
 - *Is safe and lifelong;*
 - *Offers legal rights and social status of full family membership;*
 - *Provides for physical, emotional, social, cognitive and spiritual well-being; and*
 - *Assures life-long connections to birth and extended family, siblings and other significant adults, family history and traditions, race and ethnic heritage, culture, religion and language.*

Note: *Temporary foster parents and guardians-ad-litem do not meet this definition of family.*

Family-Driven:

Family-driven means families have a primary role in decisions regarding their children as well as the policies and procedures governing the well-being of all children in their community, state, tribe, territory and nation. This includes, but is not limited to: (1) Identifying their strengths, challenges, desired outcomes/goals, and the steps needed to achieve those outcomes/goals; (2) Designing, implementing, monitoring, and evaluating services, supports, programs, and systems; (3) Choosing supports, services, and providers who are culturally and linguistically responsive and aware; and (4) Partnering in decision-making at all levels.

Family Partner/Parent Peer Partner:

A parent with lived experience raising or who has raised a child receiving services from any child-serving system. The Parent Peer Partner provides intentional peer support to the parent or primary caregiver of the child through strategic self-disclosure related to their own family experience. Parent Peer Partners provide non-adversarial advocacy and suspend bias and blame in all interactions with parents and professionals. They encourage parents to practice self-care and build on their strengths. Parent Peer

Partners provide hope, build connections and linkages, and encourage parents to utilize their voice to be part of a collaborative problem-solving process. Parent Peer Partners also participate in program and system development through their membership on planning and policymaking bodies at various levels, including Boards of Directors of residential programs. Some also have specific expertise in residential interventions, substance abuse, family search and engagement, the child welfare, mental health, and/or juvenile justice systems. They may also be referred to as a family partner or advocate, family peer support specialist, peer advocate, etc.. Parent Peer Partners may be employed by a Family Run organization (FRO), a public entity (e.g., mental health, child welfare, juvenile justice, or substance abuse departments), or by community or residential providers.

Indian Child Welfare Act (ICWA):

Indian Child Welfare Act of 1978 is a Federal law that governs the removal and out-of-home placement of American Indian children. The law was enacted after recognition by the Federal Government that American Indian children were being removed from their homes and communities at a much higher rate than non-Native children. ICWA establishes standards for the placement of Indian children in foster and adoptive homes and enables Tribes and families to be involved in child welfare cases.

Linguistic Competence:

The capacity of an organization and its staff to communicate in a way that is easily understood by diverse audiences, including persons of limited English proficiency, those with low literacy or non-literacy skills, and individuals with disabilities. Linguistic competence requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures, and dedicated resources to support this capacity.

Organizations:

Consist of residential, congregate care (e.g. group homes), and community-based providers of all types (e.g., mental health, education, juvenile justice, schools, public systems, family run organizations, etc.).

Outcome data:

Post-discharge measures of youth and family functioning in key domains compared to baseline.

Perceptions of Care:

An assessment of the child and family's perception of the quality and effectiveness of the services they received. Perception of care research is designed to explore the relationships between different consumer perceptions, actual practice, and outcomes, using survey and interview methods.

Performance Data:

Measures of the practices and processes that occur in the provision of care, services, and supports. These measures can be assessed through observation, survey, interview, chart review or use of existing administrative datasets.

Quality Improvement Collaborative:

The Quality Improvement Collaborative (QIC) is one of several methodologies used by the Building Bridges Initiative (BBI) to support residential and community stakeholders in implementing practices that align with research and evidence on realizing sustained positive outcomes for youth and their families post-residential discharge. The QIC supports designated leaders and staff from different residential programs in adopting and/or making improvements in promising, best and/or evidence-informed approaches/practices by creating an environment in which participants can learn from experts in the identified topic areas as well as from each other. QIC Implementation Sites will typically consist of 4 to 6 programs or provider sites and include partnership with and coordination with system oversight agency leaders.

Residential Intervention:

A use of residential programs (residential treatment centers, group homes, etc.) in all systems (child welfare, juvenile justice, mental health, etc.) as a resource for youth and families for whom services and supports in the community have not been effective, to provide a range of practices in the residential building as well as at home and in the community. This term, used as an alternative to the traditional terms “residential care” or “residential treatment”, encompasses the many different types of treatment approaches and supports that may be effectively implemented in home and community settings as well as in the residential program. It connotes that “residential” is not just a placement but a form of intervention that can be used in targeted and effective ways, connected with home and community resources, and delivered with an urgency for the youth to return to family and community.

Residential Program:

A program providing a residential intervention for children and youth that meets the following criteria:

- It provides 24-hour residential intervention services, in the program facility and/or in the home and community. It serves children and youth primarily under the age of 24.
- It is a congregate care setting serving three or more youth and is not a foster home.
- It is provided by an organization, the primary purpose of which is the provision of individually planned programs of treatment and support services in the context of residential interventions for youth who have needs temporarily unable to be met effectively by any of the different child and family serving systems (e.g., Mental Health, Child Welfare, Juvenile Justice).
- It has a clinical program within the organization that meets requirements of applicable national, state, and local regulation and any applicable accrediting bodies.

Restraint and Seclusion:

A *restraint* is any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a child to move his or her arms, legs, body, or head freely; or a drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.

Seclusion is the involuntary confinement of the child to a room or area; a situation in which a child is restricted to a room or area alone and staff physically intervenes to prevent the child from leaving is also considered seclusion.

Safety Plan:

An individualized plan developed with the youth and family to support the youth emotionally and behaviorally. The plan should: (1) specify individualized, proactive constructive practices designed to support positive behavior and prevent the need for emergency safety interventions; (2) outline trauma-informed and culturally appropriate and responsive approaches, identify a child's triggers, provide guidance on appropriate environmental supports; (3) define the role of family members; (4) specify child-defined soothing strategies; and (5) include child-specific parameters for the use of emergency safety interventions.

A safety plan includes both pro-active components to promote safety and planned responses to safety risks that might arise in the course of a residential intervention, whether in the program, at home, or in the community. Safety plans would carefully describe potential safety issues (based on the needs and circumstances of each child and family) and define needed training, supports, services and response protocols to increase the likelihood of positive outcomes when safety risks occur. Sometimes referred to as an Individualized Behavior and Emotional Support Plan.

Soothers:

Supports, behaviors, activities and materials that have a soothing or comforting effect and reduce or prevent agitation for a youth, parents, siblings, staff. These include self-care, sensory materials, trauma-informed interventions, etc. and are typically identified by the youth and family or suggested by staff based on observation and experience and/or recommended by a certified Occupational Therapist.

Strengths-Based:

Approaches deriving from the belief that successful outcomes result when youth and families are empowered to use and develop their inner resources and strengths. All planning and services consider the child and family to possess attributes which should be used to help them be successful in treatment and in life. The team takes time to identify, recognize and validate the skills, knowledge, insight, and strategies that the child and family has used to meet the challenges they have encountered, as opposed to a focus on deficit areas.

Strengths-Based Assessments:

Assessments that elicit information on: 1) the youth's and family's assets and resources across all systems and life domains, both formal and informal; 2) areas of strengths whether personal or environmental; and 3) current skill abilities of the youth and family members, in order to incorporate these assets/resources into the plan of care.

Supports (Informal and Formal):

Assistance, activities, and services provided to a youth and family that helps them address the challenges in their life, feel connected and or hopeful, experience competence and well-being. Supports are an important component of treatment and safety plans. They include formal support services (typically provided by professionals) and informal supports (received through family, friends, religious organizations, community groups, casual community relationships, relationships with pets, etc.). Supports can also be clustered into: (1) relational opportunities (support groups, warm-lines, advocacy training, respite); (2) recreational and expressive opportunities (sports, arts, etc.) and (3) material support (e.g., transportation, childcare during meetings, financial assistance through unrestricted dollars, etc.).

System of Care (SOC):

A coordinated network of community-based services and supports organized to meet the challenges of children and youth with serious needs and their families. SOC is not a program; it is a philosophy of how care should be delivered and an approach to services that recognizes the importance of family, school, and community. SOC seeks to promote the full potential of every child and youth by addressing their physical, emotional, intellectual, cultural, linguistic, and social needs. Families and youth work in partnership with public and private organizations to design trauma-informed and responsive services and supports that are effective, that build on the strengths of individuals, and that are culturally appropriate and responsive. References to system of care in this document refer to all such systems, including, but not limited to SAMHSA-funded communities.

Transition Plan:

A part of the overall treatment plan that describes the progression of activities required to ready the youth and family for discharge and support their success as they transition to home and permanency, foster care, or higher or lower levels of intervention. The transition plan encompasses school, work, housing, income supports, linkages with ongoing treatment, etc. For some youth 'aging out' of the child-serving system, the transition plan refers specifically to preparation for living independently in the community. Transition plans are developed by the Child and Family Team when the child enters residential intervention to guide work toward integration with efforts in the community and a timely and expeditious return home.

Trauma-Informed and Responsive Services:

Services, supports or programs provided under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma, in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions, to address trauma's consequences and facilitate healing. (Families First Preservation Services Act HR 1892-17 Part IV.

(4) (B))

Trauma informed supports and services are grounded in and directed by a thorough understanding of (1) the neurobiological, biological, psychological and social effects of overwhelming stress, trauma and violence in humans; (2) the significance in the prevalence of these experiences in children, youth, and adults who receive services; (3) the fact that many behaviors are associated with experiences of overwhelming stress and trauma the individual has suffered and/or the stresses of the immediate situation, and (4) the applicability of this understanding to co-workers and organizational phenomena. Trauma-informed programs define specific competencies for staff regarding trauma, trauma-informed interpretations of behavior, and trauma-informed service and support planning. Trauma-informed interventions and practices support healing and positive mental health for youth, families and all involved in the residential intervention, significantly contribute to the reduction of both challenging/unsafe behaviors and the use of restraint and seclusion by staff, and improve perception of care and long term sustainable positive outcomes.

Treatment Plan:

A written document that lists and describes all the services and supports a youth and family will receive. Plans are expected to be trauma-informed and responsive, culturally appropriate and responsive, and measurable. Plans include information about: (1) a youth's and family's strengths, concerns, and needs; (2) what the services and supports are designed to accomplish, including youth-specific behavior support and soothing; (3) how and when progress will be assessed; and (4) plans for discharge, transition support and services. Also referred to as a Treatment and Support Plan.

Youth Peer Support Partner/Specialist:

A young person, typically between the ages of 15-25, who utilizes lived experience to educate, inform, motivate, and inspire others to create positive systems change. A Youth Peer Support Partner (YPSP) can be a youth, young adult, or adult who provides individual and group support, training, and advocacy for youth receiving services. YPSP's may work for provider organizations or for an independent organization. Some YPSP's have received services as a child or adolescent. The role may also be referred to as an advocate, peer advocate, Youth Peer Support Specialist, youth coordinator, or peer mentor.

Youth-Guided:

Services and supports in which children and youth are invited and empowered to make decisions and provide input into their own treatment plan as well as the policies and practices of the organization, with support from the organization and their community. Youth-guided care is grounded in the belief that:

- Young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives.
- Young people should have a role (including serving on Boards of Directors) in designing the policies and procedures governing services and supports for all youth in the organization), community, state, tribe, territory and nation.
- Young people should have a sustainable voice in creating a safe environment that enables a them to gain self-sustainability in accordance with his/her culture and beliefs.

A youth-guided approach identifies a continuum of power and choice that young people should have based on their understanding and maturity in this strength-based change process. Youth-guided also means that this process should be fun and worthwhile. "Youth-guided" is frequently used interchangeably with "youth directed" and "youth-driven".

For more information and resources related to these terms and BBI,

please visit the BBI website:

www.buildingbridges4youth.org or

E-mail BBI:

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