

# IMPLEMENTING EFFECTIVE SHORT-TERM RESIDENTIAL INTERVENTIONS

A BUILDING BRIDGES INITIATIVE GUIDE



Building Bridges  
INITIATIVE

Advancing Partnerships. Improving Lives.

**FOREWORD**

*July 2017*

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The Building Bridges Initiative (BBI) and the BBI Advisory Committee acknowledge the content presented in this publication represents the data, representations, and opinions offered by the participating individuals and organizations and do not necessarily reflect the views, opinions or policies of the BBI. The BBI also recognizes that the participating organizations are at different stages in their effort to change residential intervention practices and reduce lengths of stay. Because organizations are continually evolving and data changes, the BBI is only able to attest that the information presented at the time this Guide was drafted was verified by the participants as being factually correct and consistent with the service described.





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# EXECUTIVE SUMMARY

If you think residential intervention cannot change - *think again*. Innovative leaders are rethinking and redefining what residential intervention is and where it is delivered. By studying the research and implementing new methods, exemplary providers are improving the outcomes for youth and families. Cutting-edge effective residential intervention now means providers are creatively working with youth and families in the home, in the community, and as briefly as possible – often for three months or less (Blau, Caldwell & Lieberman, 2014).

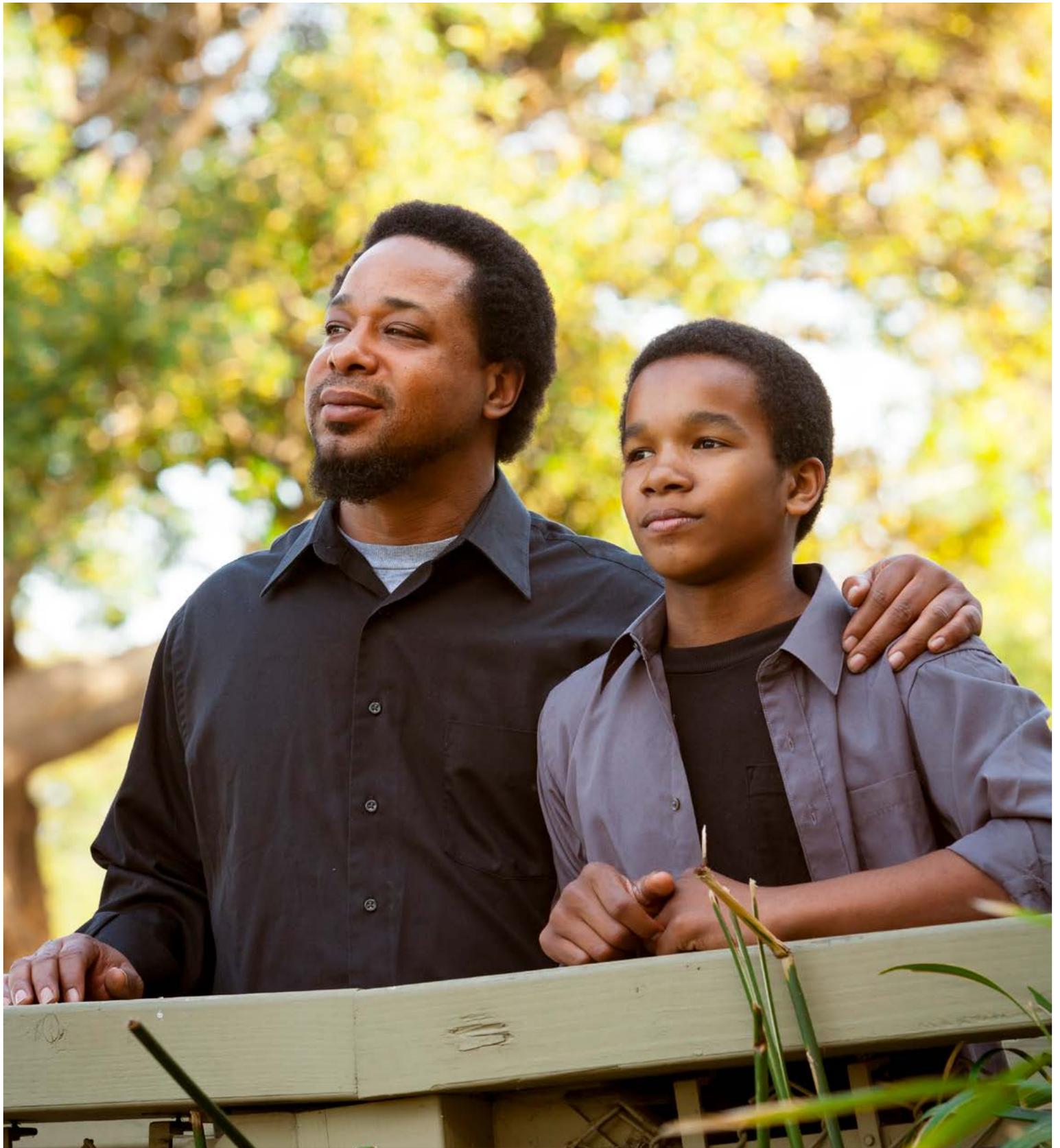
But making the leap to short-term flexible residential intervention without acknowledging the historical context, developing a framework for change, or the ability to access resources could make wary providers feel like they are jumping off a business cliff without a net. Recognizing this challenge and the pressure residential leaders face with fewer referrals and regulators and funders demanding accountability for effective services and durable outcomes, the Building Bridges Initiative developed this Implementation Guide. It is intended to be a ‘virtual safety net’ and a resource to start this change process. The Guide provides the rationale for change, a pragmatic framework to create change, and specific examples of organizations and their leaders that are already walking the walk and available to talk. In other words, residential providers who want to improve their service and outcomes do not have to go it alone and provider-experts are available to help.

This Guide is grounded in evidence-based practice (EBP) and practice-based evidence that reflects the wisdom and inspiration of more than 20 exemplary leaders who are transforming their services to enhance their effectiveness and their bottom line. Each leading provider agency identifies specific strategies which are organized into “7 Essential Elements of Short-Term Residential Intervention” that are encapsulated with brief “action snapshots” followed by more detailed “common tasks” and specific examples from provider-experts:

- » Effective leadership
- » Family and youth engagement and inclusion
- » Workforce development
- » Practice strategies and tools
- » Using data to inform practice
- » Quality improvement
- » Fiscal strategies

The provider-expert approaches align with the Six Core Strategies<sup>®</sup>, an EBP and organizational change framework, which provides a template for managing the process. To further support the shift to short-term service delivery – fiscal, policy, and administrative recommendations and resources are also offered.

Ultimately, the goal of this Guide is to help you recognize the emerging best practices in residential intervention.



With this new information to guide transformation, you can answer the crucial question,

**“Are we achieving sustained positive outcomes for the youth and families we serve?”** with an emphatic – **“Yes!”**

## DEFINITIONS

For purposes of this Guide, the terms listed are defined as follows:

**Culture.** This term means an “integrated pattern of human behavior that includes thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group. The totality of ways of being passed from generation to generation. It includes but is not limited to history, traditions, values, family systems, and artistic expression. It applies to groups such as those based on race, ethnicity, immigration or refugee status, tribal affiliation, religion or spirituality, sexual orientation, gender identity or expression, social class, and abilities” (National Association of Social Workers [NASW] Cultural Competence Standards, 2015).

**Cultural Competence.** This term refers to “the process by which individuals and systems respond respectfully and effectively to people of all cultures, languages, classes, races, ethnic backgrounds, religions, spiritual traditions, immigration status and other diversity factors in a manner that recognizes, affirms, and values the work of individuals, families, and communities and protects and preserves the dignity of each” (NASW, 2015).

“A set of congruent behaviors, attitudes, and policies that come together in a system or agency amongst professions that enables the system, agency, or those professionals to work effectively in cross-cultural situations” (Cross, Bazron, Dennis, & Isaacs, 1989).

**Family.** This term refers to important people in the life of the youth who are identified as “family.” This may be one or more parents or kin, close friends, or other people.

**Family Advocate.** A Family Advocate is a family member with lived-experience who represents the family perspective and generally serves as an advocate for fami-

ly-members of youth served in a residential service. Several providers who participated in the development of this Guide developed professional roles for family members with lived-experience. The roles and job titles may differ somewhat (e.g. Family Advocate, Family Partner, Parent Partner, Parent Advocate, and Family Liaison) but the defining feature of advocacy for families from the family perspective is constant.

**Family-Driven Care.** This term means that families are recognized as the primary decision makers for their children not only in the home/community but during the residential intervention as well. In addition, family roles and perspective are integrated into residential intervention policies, procedures and practices.

**Linguistic Competence.** “The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse groups including persons of limited English proficiency, those who are not literate or have low literacy skills, individuals with disabilities, or those who are deaf or hard of hearing. It requires organizational and provider capacity to respond effectively to the health literacy and mental health literacy needs of populations served. It requires policy, structures, practices, procedures and dedicated resources to support this capacity” (Goode & Jones, 2009).

**Residential Intervention.** This term refers to all forms of non-hospital, community and campus-based residential programming (e.g. group home, intensive group home, congregate care, residential program, residential treatment center, residential treatment facility, residential treatment program, residential center, psychiatric residential treatment facility, short-term residential treatment program, shelter program, therapeutic residential care, respite program, etc.) unless otherwise specified (Blau, Caldwell & Lieberman, 2014).

**Short-Term.** This term means less than 6 months, unless otherwise specified. Most programs identified in this Guide have achieved or are working on lengths of stay closer to 3 months compared to the national average length of stay in congregate care of 8 months (United States Department of Health and Human Services, Administration

for Children and Families, 2015).

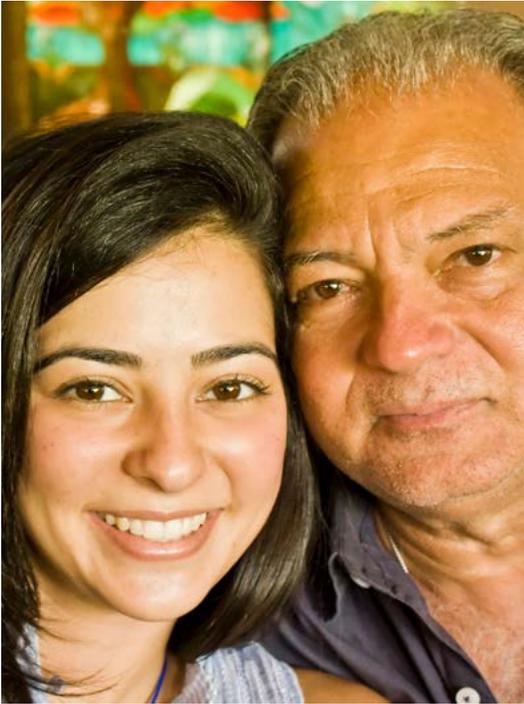
**Six Core Strategies®.** This term refers to the evidence-based practice and framework using six strategies (leadership, workforce development, using data to inform practice, prevention tools, consumer roles and inclusion, and debriefing – as part of an overall quality improvement focus) to reduce conflict, violence and the use of seclusion and restraint. It is a framework that can be applied to any number of organizational challenges to create positive change (LeBel, Huckshorn & Caldwell, 2014).

**Sustained Positive Outcomes.** This term refers to the long-term (at least 1 year, preferably multiple years) positive effect of residential interventions as demonstrated by objective, measurable improvement in relevant life domain(s) (e.g. home/community stability and tenure, school attendance and achievement, etc.) post transition/ discharge from a residential service.

**Youth.** This term means both children and adolescents (up to age 18) unless otherwise specified.

**Youth/Peer Advocate.** A Youth or Peer Advocate is a young adult hired to work in the residential program to serve as an advocate for the youth-served. Generally, the Advocate is between the ages of 16-25 (sometimes older) with lived-experience that is often from the same system in which he or she is working (adapted from Lombrowski, 2009).

**Youth-Guided Care.** Youth-guided means that young people have the right to be empowered, educated, and given a decision-making role in the care of their own lives as well as the policies and procedures governing care for all youth in the community, state and nation. This includes giving young people a sustainable voice and then listening to that voice. Youth-guided organizations create safe environments that enable young people to gain self-sustainability in accordance with the cultures and beliefs with which they identify. Further, a youth-guided approach recognizes that there is a continuum of power that should be shared with young people based on their understanding and maturity in a strength based change process. Youth-guided organizations recognize that this process should be fun and worthwhile (Youth Move National, 2017).



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## INTRODUCTION

# RESIDENTIAL INTERVENTIONS IN PERSPECTIVE



Residential intervention has a long history in the United States dating back to the early 1700s with the opening of the first orphanage in New Orleans (Radbill, 1976). The intent was to create a protective environment and corrective experience for youth outside the home away from their family (Radbill, 1976). From those early roots, program-centric practice developed: youth were treated without their family, staff assumed a parental role, and rules and structure were imposed (Radbill, 1976). While residential intervention has evolved and innovated over time, many of these root practices remain.

Through the years, the field was criticized for its outcomes (Walter & Petr, 2007). Some believed that residential services should come with a “black box warning” (Coen, Libby, Price, & Silverman, 2003). Others suggested the intervention could “make children worse” (Dodge, Dishion, & Lansford, 2006). But, several experts cautioned against sweeping judgments about residential intervention because of the lack of operational distinctions, the diverse types of programs and populations served, and limited comparable data (James, 2011). As a result, despite long-standing use — residential intervention was not recognized as a substitute for a home and family or an evidence-based practice (James, 2011). The residential field found itself in need of a strong evidence base and sustained positive outcomes for those they served.

Now, the professional literature is identifying promising practices in residential intervention which are associated with positive benefits, such as: actively engaging youth and families, ensuring active school and community connection, and keeping residential intervention as short as possible (Blau, Caldwell & Lieberman, 2014; Frensch & Cameron, 2002; James, 2011; James, Zhang, & Landsverk, 2012; Noflet et al., 2011). Exemplary leaders are not only heeding this information, they are becoming “... the new generation of passionate, hardworking leaders willing to “do whatever it takes” to build a new model for residential...” (Blau, Caldwell & Lieberman, 2014, p. 228). They are taking bold action to improve their service and achieve better results. They are creating meaningful, positive outcomes by: promoting time spent at home and in the community (Huefner, Pick, Smith, Stevens, & Mason, 2015); minimizing lengths of stay; engaging families during and after residential intervention (Casey Family Programs, 2016); and actively supporting staff and persons-served in relevant, important ways (Blau, Caldwell & Lieberman, 2014; Levison-Johnson & Kohomban, 2014).

The challenge for the field is that some providers do not know about the potential negative effects of residential intervention nor are they familiar with emerging approaches associated with sustained positive benefit. Similarly, some providers may have partial information about residential effectiveness but require support to transform their practice. This is why the BBI developed this Guide – to help interested providers learn from peer-leaders willing to share innovations, outcomes, and lessons learned in their organization’s evolution of residential intervention. Because providers and public systems cannot change residential intervention independently from each other, this Guide underscores the importance of partnership and collaboration and acknowledges the essential drivers of sustained practice change including fiscal strategies and the role of oversight agencies. This information may also be useful for state agency colleagues to review and consider for their own system change processes, such as contracting/recontracting, standard-setting, and regulatory reform. Likewise, entities with oversight responsibility can use the information in this Guide to promote making residential interventions more effective, as brief as possible, and as culturally and linguistically responsive to the needs of youth and families served.

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**This Guide underscores the importance of partnership and collaboration and acknowledges the essential drivers of sustained practice change including fiscal strategies and the role of oversight agencies.**

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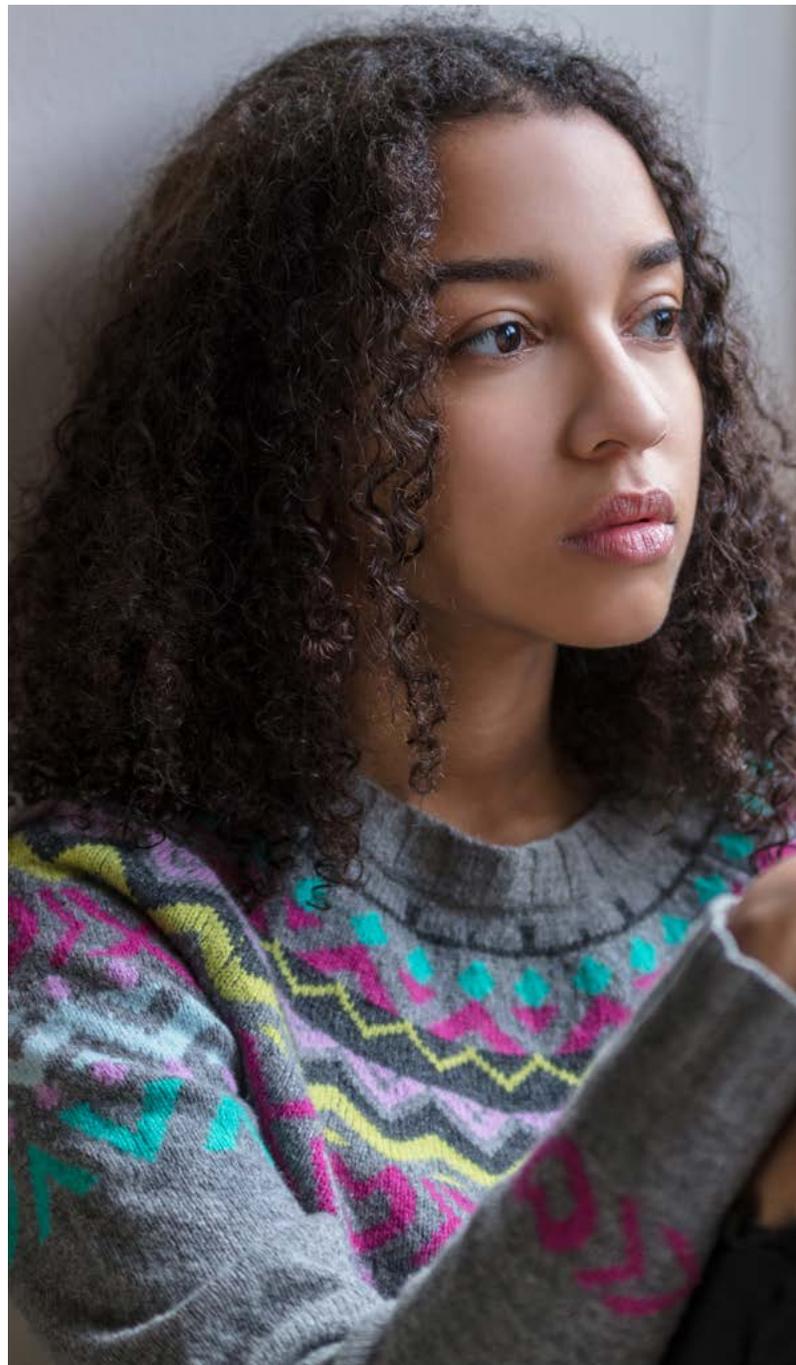
# PROJECT BACKGROUND, OBJECTIVES & PROCESS

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This Guide was developed by a team organized by the BBI who represented residential providers, trade organizations, state government, family and youth advocacy experts, cultural and linguistic competency experts, and the BBI leadership (see Appendix A). The team established clear objectives for this Guide: a) provide specific strategies to change residential interventions to effective short-term programs; b) provide specific practices to achieve sustained positive outcomes; c) provide examples of programs that transformed into successful short-term services; and d) provide fiscal, policy and administrative practices to support short-term service delivery.

**To achieve these objectives, the team conducted an extensive search for exemplary providers who initiated a change process designed to maximize positive outcomes, engage youth and families, and minimize length of stay.**

National organizations, trade associations, advocacy groups, state and federal agencies and providers from across the country were canvassed. More than 20 organizations with innovative, transparent leaders were identified. The leaders were then interviewed using a questionnaire designed to elicit transformation specifics and recommendations.



Similar tasks and change-related elements emerged when the transcripts from the provider interviews were analyzed and synthesized. The commonality of approaches was remarkably consistent with the Six Core Strategies<sup>®</sup> (2017), an evidence-based practice to create organizational change. The Core Strategies<sup>®</sup> – leadership, workforce development, youth/family inclusion, using practice strategies and tools, using data to inform practice and quality improvement, including debriefing – provide a pragmatic framework to present this information. While the Core Strategies<sup>®</sup> help to guide the efforts within the provider’s organization,

incorporating change management strategy with external purchasers and stakeholders was key to the success of this work. For this reason, other essential actions such as: communication, collaboration, and partnership need to pervade each provider’s external efforts and be incorporated within each Core Strategy. Because much of the demand for shorter residential stays and accountability for child and family outcomes is driven by funders, fiscal approaches and the role of oversight agencies to support the change process are included.

Each of the six essential elements of short-term residential intervention are described in a few words in an **“ACTION SNAPSHOT”** followed by more detailed **“COMMON TASKS.”** Specific program examples, by Core Strategy, illustrate each of the elements. The program examples highlight key features of each organization’s change innovations but it is not a complete roster of all actions taken by each program. The concise practice profiling format is intended to help residential providers quickly discern and extract key steps, apply the information to their organizations, and start their own change effort. It is also intended to accelerate the implementation process and reduce the natural lag that can occur when starting a new initiative.

Finally, a Resource Section is provided with more detailed information (research, technical reports, articles, etc.) to review and share with residential staff and stakeholders as you begin the change process. Contact information for the leaders who are identified in the highlighted programs is also offered. These leaders are available to respond to questions that may arise after you read this material. Their contact information listed is in Appendix B.



SECTION THREE

# ESSENTIAL ELEMENTS

## OF SHORT-TERM RESIDENTIAL INTERVENTION

ESSENTIAL  
ELEMENT  
01

### Effective Leadership

*One of the most important elements in creating an effective short-term (i.e. less than six months, preferably under three months) residential intervention is bold, committed leadership that stays attuned to the needs of those they serve, their staff, and the evolving industry. They also recognize the importance of cultural diversity within each strategy employed. Effective leaders begin their change process in different ways: some by pragmatic imperative, some by legal or survival threat, some by fiscal necessity, and some by simply by doing the right thing and making the necessary decisions to advance in that direction. Regardless of the catalyst, all effective leaders have a strong sense of urgency and responsibility to improve their organization's services quickly and decisively.*

#### **ACTION SNAPSHOT**

- HONESTLY SELF-ASSESS.
- PREPARE FOR CHANGE.
- MOBILIZE.



## COMMON TASKS

- » Studied their data (e.g.: population needs, cultural and diversity needs, service needs, community needs, organizational culture, outcomes by service, recidivism); researched and read current residential intervention literature; and conducted a gap analysis of what was missing (e.g. to improve positive outcomes post residential service; to shorten lengths of stay; to successfully move from a youth-centric to family-centric treatment and support model; to support staff in working with families in the community; to more effectively partner with community providers and the natural family support systems)
- » Created a new vision (e.g. as above) based on their self-assessment and plan for change with a specific goal(s)
- » Educated and involved their Board and staff and got support and buy-in to a new residential intervention model
- » Formed a steering committee with staff “champions” at all levels of the organization and implemented effective communication methods to promote the desired change
- » Implemented weekly accountability mechanisms to ensure effective care for every youth and family and rigorously self-audited for effectiveness or lack thereof (e.g. review of medical records and acuity indicators [restraint/seclusion/elopement/critical incidents])
- » Actively engaged system collaborators (e.g. funders, regulators, judicial partners, community providers) and youth and families in the self-study, planning and implementation process
- » Adopted a customer service orientation with youth, families, funders, oversight agencies, and community service partners (“The customer is always right”)
- » Expanded services or collaborated with others to ensure community supports were available to support youth and families in the home/community
- » Created the tools and resources to promote the change
- » Held tightly to the new vision and new goals despite resistance and challenges

**“My discharge planning as far as I knew did not start until after at least 9 months.  
I am only visiting [this] placement, home is where I belong.”**

*name withheld*

PROGRAM  
EXAMPLE

## THE CHILDREN'S VILLAGE, NEW YORK

*In 2004, The Children's Village committed to organizational change focused on ensuring that children and families received what they need most; an organization responsive to family need and an organization committed to helping children find a place of unconditional love and belonging rather than system dependency.*

Jeremy Kohomban, the President and Chief Executive Officer (CEO), recognized that residential intervention had its place, *"like an emergency room – to be used only when necessary"* and reconciled the need for residential intervention with a fundamental philosophic position: *"The key issue is belonging. Kids belong with people and not in a place. No matter how beautiful your residential place is, it is not a place to grow-up. You cannot compare your facility to a neighborhood and community, and you can never dispute the reality that a family is more important. If you do, you don't have the foundation to make this change."* With full support of the Board of Trustees, The Children's Village made many changes, including reducing

their average lengths-of-stay across their 13 specialized residential programs (with some case-specific exceptions for very high-risk youth), creating long-term aftercare for those discharged and investing in efficacious 21-day stabilization programs. In doing so, The Children's Village surpassed all of their target goals for key positive outcomes in their cohorts: a) youth either graduated from high school or were still in school (92%); b) youth were either in school or working at least part-time (93%); c) youth maintained stable housing (100%); and d) youth did not return to care / remained arrest free (85%).

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**"The key issue is belonging. Kids belong  
with people and not in a place."**

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## Essential Element 01: Effective Leadership

### Some of the specific strategies used to achieve these results included:

- » Making difficult fiscal decisions, such as finding resources within existing budgets to support the changes and fundraising
- » Changing staff training and intentionally embedding foundational concepts of belonging, pro-family practice, and addressing cultural and linguistic needs
- » Explicitly tying their residential change effort to their “Undoing Racism” initiative because the local and national data indicate that black, brown, and native youth are overrepresented at all levels of the system and once in residential care, they stay longer and have some of the worst outcomes
- » Investing in Parent Advocate positions and ensuring they were culturally diverse and an active part of the treatment teams
- » Creating a culturally diverse Parent Leadership Council
- » Requiring senior leaders to lead by example and model transparency, openness, and youth/family value by having an open-door policy, being available to talk to parents/youth at any time, and moving away from a “chain of command” process
- » Studying their data and recognizing that 15% of the youth and families served by the organization used 85% of their resources, so new clinical programming was sought and implemented to more effectively work with families in communities (Multi-Systemic Therapy and Functional Family Therapy [FFT])
- » Changing the organization’s policy to allow program staff to become foster parents to youth in care without staff having to resign their role. According to Kohomban, *“With over 1,300 staff in the organization and schools, we needed to engage them in a solution. The protections are simple. Staff who step-up are interviewed and when appropriate, a plan is developed. To ensure boundaries and to manage risk, we developed very clear policies and we transfer the oversight of the case and the relationship to another independent NY State approved agency. We don’t interfere with that agency’s approach and decisions; all we do is lose the money that we would otherwise have received by simply keeping the teen in care until age 21!”*
- » Providing long-term aftercare until age 23 and ongoing as needed



### SUPPORTING STAFF IN BECOMING FOSTER PARENTS

“With over 1,300 staff in the organization and schools, we needed to engage them in a solution. The protections are simple. Staff who step-up are interviewed and when appropriate, a plan is developed. To ensure boundaries and to manage risk, we developed very clear policies and we transfer the oversight of the case and the relationship to another independent NY State approved agency. We don’t interfere with that agency’s approach and decisions; all we do is lose the money that we would otherwise have received by simply keeping the teen in care until age 21!”

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*Jeremy Kohomban*  
President and CEO

PROGRAM  
EXAMPLE

## KVC HEALTH SYSTEMS, KANSAS

*KVC Health Systems embarked on a “learning journey” to meet the future by being bold. Their journey was fueled by an organizational culture that “is never satisfied” and a fundamental belief that “children belong in families, in the community.” KVC strives to reach beyond their goals and vision for the best outcomes for children and families.*

Chief Clinical Officer, Chad Anderson, believed effective leaders must “think nimble and continually adapt.” Dissatisfied with increasing lengths of stay and difficulty serving youth with challenging behavior, KVC recognized they had not appreciated the unique challenges of youth and families and the need for greater systemic integration. They visited organizations that had developed innovative programming

and sought out, designed and implemented a short-term model that could be used both within the residential service and with families and foster families (Trauma Systems Therapy [TST]). They also committed to effective outcomes and ultimately reduced their average length of stay in their residential treatment centers from 365 days (1996) to 59 days (2015).

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**KVC strives to reach beyond their goals and vision  
for the best outcomes for children and families.**

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## Essential Element 01: Effective Leadership

### Some of KVC's specific strategies included:

- » Requiring all assessments be completed by no later than 72 hours after admission
- » Having leadership work on all shifts to understand operational obstacles, shift needs, and advance change through effective modeling for employees so that short-term lengths of stay and successful work with families could be achieved
- » Requesting state partners/funders and community providers support their position that families are vital to effective treatment and support the program's efforts to ensure their participation
- » Implementing active, ongoing outreach to families during treatment (7-10 contacts/week) to ensure engagement and treatment progress
- » Addressing language and culture, e.g. changed "child welfare visitation rooms" to "wellness rooms"
- » Adopting no reject and/or no eject approach
- » Developing comprehensive and sophisticated data systems that monitor treatment effectiveness (e.g. length of stay, return to care post-discharge, readmission, permanency), inform service development, collaborate with partners (e.g. judges), and demonstrate to employees the outcomes they successfully helped to achieve
- » Committing to permanency and ensuring a permanency focus permeates every service the organization offers. Hiring more than 20 therapists to advance permanency work in their foster care service and ensuring all clinical staff in their programs are trained in the same evidence-based practices, including residential interventions, to ensure continuity and consistency in services to youth and families
- » Implementing policies and procedures to reflect core values: children belong in families, trauma-informed, youth and family-centric practice and ensure the family is never excluded



Essential Elements of Short-Term Residential Intervention

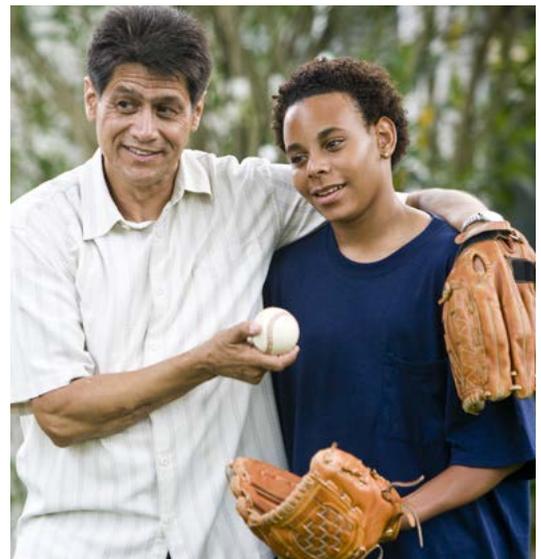
ESSENTIAL  
ELEMENT  
02

## Family & Youth Engagement and Inclusion

*The goal of an effective short-term residential intervention is to rapidly help families and youth learn to navigate life challenges and live successfully together in the community. To achieve this, families and youth must be active participants in the service and process, otherwise the impact of the intervention will be limited and the outcomes diminished. Strong philosophic imperatives are key to creating organizational culture and practice change: a) youth belong with their families; b) families must be respected and engaged; c) interventions should be in the youths/families' homes and communities; and d) out-of-home residential interventions should be as short as possible.*

### ACTION SNAPSHOT

- PHILOSOPHICALLY COMMIT.
- EMBRACE TRANSPARENCY.
- ENGAGE FAMILIES AND YOUTH AS VALUED PARTNERS.



## COMMON TASKS

- » Committed to family inclusion — no matter what. Used Family Finding/Family Search and Engagement strategies to ensure each youth had family identified and involved
- » Engaged family and youth in an array of activities: focus groups, planning efforts, ongoing committees, and advisory councils
- » Invested in parent engagement (e.g., money for transportation for youth to spend frequent [daily, multiples times/week] time at home; resources for interpretation/translation services; and providing parent education opportunities preferably in the families' homes/communities)
- » Created new roles and hired culturally diverse family and youth advocates, family leaders, family partners, family liaisons, etc.
- » Brought culturally diverse family members and youth/young-adult graduates onto the Board of Trustees and governing bodies
- » Critically re-examined and changed policies, procedures, protocols and practices that were not consistent with family-driven, youth-guided and culturally and linguistically competent practices
- » Recognized youth and family members as co-experts and involved them in new-hire interviews, orientation classes, ongoing workforce education and trainings, quality improvement activities, liaison efforts with other families, and serving on agency committees
- » Created open-door policies: no restrictions on calls between youths and their families (in fact, encouraging calls multiple times per day), encouraging youths' spending time at home frequently, welcoming families on site any time (unless court-ordered)
- » Provided as much intervention in the home as possible: pre-admission meeting, service planning/treatment reviews, initial assessment, ongoing treatment, follow-up and outreach/support post-transition from the program
- » Hired culturally diverse clinicians to reflect the community being served who had previous experience working in the community/family homes
- » Expanded treatment interventions for youth and families, e.g., trauma assessment, motivational interviewing, occupational therapy, and taught families' the same skills that direct care staff were taught (e.g. crisis prevention strategies, verbal de-escalation, self-calming/soothing techniques)

**“It was hard to tell in the beginning if I was being included in the plans for my treatment. At some point I was asked what my goals were and sometimes asked to copy them down from what was already written. Individual sessions, that my mother had to fight for me to receive, helped the most and family sessions — once they began to happen. I think there should be nothing about us without us!”**

*name withheld*

PROGRAM  
EXAMPLE

## SWEETSER, MAINE

*Sweetser's Family Focus program in Saco, Maine opened in 1994 and was strongly influenced by the structural family systems work at the Philadelphia Child Guidance Clinic and its founder Dr. Salvador Minuchin.*

Dr. Andrea LeMoal along with the leadership of the organization designed Family Focus to be fully family-focused and short-term with an average length of stay from three to five months.



## Essential Element 02: Family & Youth Engagement and Inclusion

### To achieve those goals, they set aside traditional milieu practices by:

- » Requiring families to commit to participate in care before the youth is admitted and accepting the work is not about “fixing the youth” but helping the family system function more effectively together
- » Keeping the family in the lead position from admission through treatment: the family gives direction to youth when on-site, if the family is off-site during a difficult moment, the family is contacted for their input in order to determine the response
- » Creating an open-door policy with no visiting hours and no telephone restrictions
- » Implementing less structured activities in the milieu to allow for maximal daily family inclusion and connection, and no level system
- » Ensuring staff receive 2 hours of clinical supervision on family work per week
- » Identifying direct care staff as: “Youth and Family Counselors”
- » Developing an “Integration Specialist” position to actively liaise with schools
- » Focusing on family/youth engagement every day, which means few group/program outings are created or scheduled, as program engagement is not the focus
- » Creating staff performance evaluations that include family engagement/treatment skills
- » Convening emergency family meetings as soon as a loss of family engagement is suspected
- » Recognizing that youths’ time spent at home on the weekends and holidays is an integral component of the program, staff will either provide support in the home or be available to consult with family by phone



**“Don’t tell me I’m doing something wrong with my children. Send someone to my house and show me the right thing to do with my children.”**

*anonymous parent of youth receiving residential intervention*

PROGRAM  
EXAMPLE

## DAMAR SERVICES, INC., INDIANA

*Damar is a 50-year old organization serving youth with intellectual and developmental disabilities and their families from the greater Indianapolis area. Damar has continually evolved to meet the needs of the community and pushed the bounds of traditional practice in order to lead to where the residential field is heading.*

In 2005, under the leadership of Dr. Jim Dalton, the organization launched a best practice effort called “Damar Best” and set into motion a series of activities to both challenge themselves and deliver effective, relevant care for those they serve. According to Jim, “It was the right time to be doing the right things. Our industry had suffered from years of failures – not meeting families’ needs and not respecting them. It was time

*to change and prioritize families.”* Implicit in Damar’s actions was the fundamental belief that “*residential intervention should be oriented not so much around removing the problems kids bring to care, but toward establishing the conditions that allow children and families to manage symptoms and crises more effectively at home and in the community.*”

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“It was time to change and prioritize families.”

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## *Essential Element 02: Family & Youth Engagement and Inclusion*

### **Some of Damar's actions to achieve this goal include:**

- » Providing residential interventions to only those youth and families who live within a 30-mile radius so that Damar staff can work daily, if needed, in the homes and communities of the families served
- » Communicating consistently that youth and family spending time together is a right not a privilege to be earned
- » Conducting pre-admission meetings in the family's home — setting the focus and intent at the outset of the intervention
- » Insisting on daily, direct contact between a youth and his/her family. If 24 hours elapses without direct contact, it is considered a critical incident, taken very seriously, reviewed at increasing elevated levels of the organization, and corrected immediately.
- » Ensuring that family member(s) have the opportunity to interview and select the clinicians and staff who will work with them
- » Ensuring that all interventions are individualized to families — incorporating program rules as guidelines — as the families are the arbiters of interventions
- » Correcting outdated, institutional language (e.g. there is no such thing as a “home visit” rather it is “family time”)
- » Ensuring all clinicians are community-based and do not have an office at the program. Their work with the family is primarily in the home/community and not in the artificial setting of an institution.
- » Recognizing the importance of supporting youth and family time at home as treatment. If the family is uneasy, staff will be in close proximity to the home (e.g. in their car nearby) to be readily available if needed.
- » Guaranteeing their outcomes and success (success = 2 years' post-discharge with no recidivism/hospitalizations). If a youth requires a return to care, Damar intervenes in the clinical and financial support (Damar funds a return to their program).
- » Actively monitoring, responding to, and tracking treatment targets associated with positive outcomes (family engagement, self-efficacy, prosocial peers, length of stay, medications, school attendance, skill development) and following youth and families progress for five years' post discharge
- » Training Direct Care staff to be family specific. Direct Care staff does not work for programs or facilities but rather for families.
- » Ensuring that Direct Care staff is empowered to provide and receive information to and from parents — encouraging and facilitating family engagement as a targeted recidivism variable
- » Ensuring that families are highly represented in the organization — on the Board, on all committees, working directly with youth, trainers, etc. Parents are often paid employees.
- » Ensuring parents receive as much training as staff members

Essential Elements of Short-Term Residential Intervention

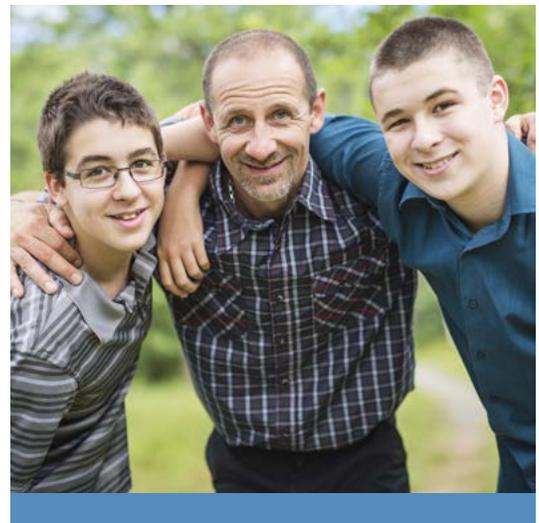
ESSENTIAL  
ELEMENT  
03

## Workforce Development

*Because leaders must rely on their workforce and delegate direct service responsibility to their staff, workforce development is critical to achieving positive results that can be sustained over time. Without a workforce, there is no residential intervention. Without an educated, diverse, and culturally and linguistically competent workforce that is mentored/supervised, service may be delivered, but success may be compromised. The challenge that all residential providers face is that funders are no longer interested in simply purchasing services. Funders want a guarantee for their investment — they want to purchase positive results. Without the promise of better outcomes, residential leaders run the risk of adversely impacting their business. Actively engaging and equipping residential staff with the knowledge, skills, and tools for engaging and working successfully with families and implementing a range of practices that correlate to achieving sustained positive outcomes post-residential intervention are key for providers to be viable and effective.*

### ACTION SNAPSHOT

- VALUE WORKFORCE.
- VALUE SUPERVISION.
- VALUE CULTURE AND DIVERSITY.
- CHANGE HIRING, TRAINING, AND PRACTICE APPROACHES.



## COMMON TASKS

- » Prioritized and actively incorporated diversity and culture in all aspects of residential operations and workforce education
- » Deliberately recruited, mentored, and supervised a diverse workforce representing the families and youth served
- » Changed staff hiring approaches by including youth and families in: job description review/development, interview question development and interview process, and staff education /orientation
- » Changed staff education framework: increased time and changed approach to orientation, probation, mentoring, and pragmatic skill development
- » Changed staff performance evaluation process by soliciting input from youth and families and conducting “360 reviews” (staff reviews their supervisor/leadership)
- » Solicited staff perspective of training needs to successfully engage and work with families in their homes and communities
- » Prioritized supervision as an essential workforce engagement strategy
- » Enhanced supervision frequency, modality, and time allocated (e.g. minimum of weekly supervision using multi-method individual and group approaches, often doubling the amount of time)
- » Supported staff creativity to seek out innovative solutions, and new methods for youth and families, and/or teach youth a particular talent/interest they may have (e.g. music, gardening, foreign language, etc.)
- » Taught staff, youth and families dispute resolution, negotiation and conflict resolution skills
- » Elevated the role of direct care staff to work as a team with program therapists and/or provide training for families in the home
- » Recognized some staff cannot make/implement intervention changes and need to be moved on to another role, setting, or career path

**“I expect someone to speak in my language when they tell me about the drugs and the treatments for my child. Do not act like I don’t understand what you’re saying just because I speak a different language.”**

***anonymous parent of youth receiving residential intervention***

PROGRAM  
EXAMPLE

## KAIROS, OREGON

*Bob Lieberman is the CEO of Kairos in Oregon and has been with the organization for more than 38 years. He passionately maintains, “We are always looking for change. It’s our calling card. It is our culture. We continually look at the evidence to change — especially youth and parent feedback and what current science tells us.”*

The drive to change was especially fueled in the 1990s when residential interventions came under fire from advocates and industry leaders who criticized the field for long lengths of stay and a fundamental failure to demonstrate effective results. According to Bob, *“We took the criticism seriously and rather than fight it, we committed to create better outcomes. We didn’t say our objective was to shorten lengths of stay. But that is what happened.”* Through active collaboration with all

community stakeholders, new youth and family role development, creating service lines, adopting a trauma-informed platform, providing a pragmatic model for staff, and helping youth and families to develop skills, Kairos has reduced the length of stay in their psychiatric residential treatment program for youth from approximately 19 months to 3-4 months.

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**“We are always looking for change.  
It’s our calling card. It is our culture.”**

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## Essential Element 03: Workforce Development

### Kairos also amplified their workforce efforts by:

- » Recognizing the power of a peer workforce by creating an on-site Youth Move chapter and hiring:
  - Seven (7) Youth or Young Adult Peer Support staff
  - Six (6) Family Support Specialists
  - One (1) Peer Delivered Services Manager
  - Additional postings/hiring underway
- » Teaching staff, families and youth about trauma and trauma-informed care
- » Choosing a treatment model that recognizes the neurobiological impact of trauma (Collaborative Problem Solving [CPS]) and teaching staff to recognize neurocognitive (“thinking”) deficits and creating on-line/e-learning platform for staff to learn CPS
- » Changing direct care staff role and title to: Skills Coaches
- » Teaching supervisors how to supervise and creating supervision expectations
- » Developing fidelity monitoring to ensure treatment/service integrity
- » Ensuring staff interventions are not retraumatizing by making restraint and seclusion a very rare event (95% reduction, only 1 episode in the past year in their young adult unit)
- » Respecting individual and family cultural and linguistic needs and incorporating into treatment and programming
- » Creating all gender-neutral bathrooms in all areas of the organization and ensuring preferred name and preferred pronouns are used
- » Creating and connecting residential intervention with their outpatient services and providing a range of supporting services to meet each youth and family where they are at ranging from traditional office based out-patient to intensive in-home supports, planned and crisis respite care, or skills coaches working in community settings with the youth (e.g. attending public school classes with the youth)



PROGRAM  
EXAMPLE

## ST. MARY'S HOME FOR CHILDREN, RHODE ISLAND

*The search for better outcomes at St. Mary's Home for Children in Providence, Rhode Island did not happen all at once. Carlene Casciano-McCann, St. Mary's Executive Director, reports their journey was incremental and evolved over time.*

The organization started by critically examining the outcomes of youth in their care and recognized that early gains made during residential intervention would decline after four to six months, when youth started to lose hope. With an average length of stay of 14 months, they studied youth with extended lengths of stay (two to three years) and repeatedly saw a deteriorating course, leading them to believe they may be doing more harm to the youth by keeping them in a residential service. A core issue, according to Casciano-McCann, was the organization was “not being aggressive in finding and

connecting with families,” even though they had made strides in implementing trauma-informed care and practices. They realized St. Mary's was treating youth's symptoms and not the larger issue — family — and that resources needed to be redirected to ensure every youth served by St. Mary's would be loved by a family. Their new goals included: a) finding, engaging, and working with families; b) getting youth home at least three times per week; and c) reducing length of stay to less than six months for each youth in a residential service.

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Resources needed to be redirected to ensure every youth served by St. Mary's would be loved by a family.

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## Essential Element 03: Workforce Development

### To accomplish these goals St. Mary's started:

- » Reading the BBI materials, which “made a lot of sense and generated excitement”
- » Studying the work of the Children’s Village (NY) and having the leadership team spend at day at their program. *“Having an opportunity to meet with an agency that was committed to what we were interested in doing, hearing about how they did the work, was so very helpful and inspirational.”*
- » Reaching out to a Rhode Island family support organization and developing a strong partnership with them, including ensuring family advocates for St. Mary’s families
- » Contacting RI child welfare and local organizations about Family Finding capabilities
- » Seeking grant funding to support more transportation and activities for youth/families
- » Writing the BBI values and practices into their strategic plan
- » Developing a “BBI Proposal” for RI’s child welfare agency to serve more challenging youth, prevent out of state placement, and provide more work with families in their homes and the community with additional staff but within the residential reimbursement rate
- » Finding creative ways to fund aftercare through private health insurers
- » Changing their clinical assessment approach (now it has two parts, focused on family and youth assessments) and developing a family-focused treatment plan with family goals
- » Changing their admission approach and doing preliminary work with families, offering to meet them at home or in the program, providing families with the BBI Tip Sheet and research on residential intervention outcomes, involving the family advocate at every step, and empowering families to make the decision about whether or not their child will come to the program
- » Hiring milieu staff to act as full-time family liaisons, *“These staff are the go between – they do community and family activities with family. . . they ensure youth goes home. . . they call families at end of their shift to talk about the shift. There is one in each residential program.”*
- » Paying attention to the family system, culture, ethnicity, and natural supports and also providing treatment based on religious preferences (e.g. working with a Jehovah’s Witness [JW] family and using curriculum and video material from the JW website at the family’s request). For youth/families with hearing challenges, American Sign Language (ASL) interpreters are actively incorporated, and staff understand: *“No talking behind a deaf client’s back”* – nothing about us without us. If the ASL interpreter is not present, there is no meeting. St. Mary’s also differentiates between customs, beliefs, and specific cultures – asking the family to self-assess on a “cultural continuum” to ensure they understand the client’s perspective.
- » Using graduate students to provide extra support with home-based services
- » Using a service dog to engage youth

Essential Elements of Short-Term Residential Intervention

ESSENTIAL  
ELEMENT  
04

## Practice Strategies and Tools

*Practice strategies and tools are important facets of residential intervention that should effectively translate and adapt what happens in the residence to the home or community. The intent of these tools is to provide a supportive resource to assist in the transition process and prevent the need for a return to out of home care. Tools and strategies that address the culture-specific needs of the youth and family are particularly useful. The effectiveness of the tools is key to sustainability. If the work of the residential intervention has been effective and the practice strategies and tools well used and integrated with the next step, the bridge back to the home, school, and/or community should be as smooth and seamless as possible. Programs that have significantly reduced their lengths of stay, and more importantly, improved sustained positive outcomes post-residential discharge, have dramatically shifted from a predominant use of practice strategies and tools focused on supporting the youth to a predominant use of practice strategies and tools focused on supporting the family.*

### ACTION SNAPSHOT

- IDENTIFY PRAGMATIC TOOLS AND STRATEGIES FOR STAFF, FAMILIES, AND YOUTH TO USE IN THE RESIDENCE, COMMUNITY, AND AT HOME TO ENSURE SUCCESS, PERMANENCE AND PREVENT RECIDIVISM.



## COMMON TASKS

- » Used a tool to assess the level of service need was consistent with the service being provided to ensure the “right service at the right time for the right amount of time”
- » Conducted active pre-admission work and developed a ‘pre-admission plan’ with youth and family-identified treatment goals and support needs, specific indicators of success, and readiness for transition
- » Created **urgency** regarding permanency and made the **first task** of residential intervention to ensure that **every youth** had a robust permanency plan that included lifelong connections, a safe and loving home, and several permanency back-up plans in the event ‘something fell apart’
- » Ensured active family engagement (including natural supports) from pre-admission through post-discharge
- » Implemented pragmatic tools to develop behavioral self-control and interpersonal management skills, e.g. taught youth, families, and staff how to mediate conflict, negotiate, and resolve disputes
- » Conducted Occupational Therapy and similar assessments to develop sensory-based strategies for self-soothing. Created pragmatic self-calming/crisis prevention and support plans to use and practice at the residential intervention and at home.
- » Used vocational assessment tools to assess youth’s vocational strengths and interests in order to create a pathway to work and a career
- » Used frequent youth and family-specific progress reports (ranging from: by shift, by day, by week, by month) to ensure active engagement and progress was occurring
- » Developed bridging services to ensure youth and family are supported during residential intervention transitions (and pre-admission and post-discharge)
- » Engaged/involved community support providers in youth/family transition/discharge/post-discharge planning (e.g. developing a community support plan, using mobile crisis and crisis stabilization resources, working with the schools in advance of the transition, etc.)
- » Requested youth and families evaluate treatment during the treatment planning/review processes (not waiting until discharge to assess satisfaction) in order to create real-time course correction and ensure satisfaction and relevance
- » Ensured close collaboration with the next level of care/service was provided post transition and discharge (e.g. meeting together in pre-transition advance, planning the transition with the youth/family and involved agencies, planning following up and contingencies if difficulty arises)
- » Connected youth with “positive peers”/community activities and culturally-responsive social connection in their home community prior to discharge
- » Connected families to other families with lived-experience who are in the community and/or ‘alumni’ of the program and supported them in different ways (e.g. transportation, education events, conducting weekly multiple family groups for new and ‘legacy parents’ on campus with both a clinical and education component, etc.)

PROGRAM  
EXAMPLE

## YOUTH DEVELOPMENT INSTITUTE (YDI), ARIZONA

*Trish and David Cocoros are Co-Executive Directors and Co-Founders of Youth Development Institute (YDI) located in Phoenix, Arizona. Over the past 20 years, they have grown their non-profit agency from a small 14-bed residential service to large multi-service organization with residential, aftercare, and outpatient services.*

YDI's residential intervention serves a coed-population ages 10–17 years, most of whom have difficulty with emotional and behavioral self-control. Their service includes a specialty program for youth with sexually problematic behavior. For the YDI team, it's "do whatever it takes" to support the youth and families they serve and to translate the resources of the residential intervention into meaningful assistance and pragmatic tools to support the transition back home or to the community.

They indicated that in their BBI short-term residential program the "driving force of our work is permanence for the youth we serve, doing the right thing, and providing the best services. Success equals permanence for the youth." This guided the changes that they were making. YDI began its program with a group of youth that had the most challenging beha-

viors and who were not able to be maintained safely in the home when discharged from other residential placements. YDI started with a good idea and revised it as they went along using data to guide the practice changes, "We started small, tested it, learned, and then went to funders with the data to get it funded." The families and youth had a lot of input into the changes. Success was demonstrated and celebrated with 70% of youth maintaining stability in their homes at 12 months' post-residential discharge and achieving an average length of stay (LOS) around 6 months.

Over the past few years, YDI has implemented the Six Core Strategies®, trauma-informed care, and sensory integration/modulation and achieved some impressive results, such as reducing restraint use dramatically (>98%) and making it a very rare event.

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**"The driving force of our work is permanence for the youth we serve, doing the right thing, and providing the best services."**

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## Essential Element 04: Practice Strategies and Tools

### YDI has achieved its goals by:

- » Providing services in the home, neighborhood, and community such as in-home and community based family and individual counseling along with behavior and family coaching
- » Deploying staff differently (e.g. using the same therapist and direct care staff [*called the BBI worker*]) from the residential intervention for aftercare services provided in the home
- » Hiring staff with degrees and skills needed to deliver the clinical services in the home
- » Extending outreach and aftercare services from 60-90 days to up to one year in order to ensure a successful transition
- » Providing crisis support and respite after a youth has returned home in order to prevent youth recidivism/ removal from the home
- » Supporting the youth around school transition (e.g. by creating an on-site day school to facilitate youth going home earlier)
- » Using strategies to support youth being successful in the community such as participating in Job Corp
- » Establishing a one-change-at-a-time approach in order to decrease anxiety and make the transition home as successful as possible
- » Using evidence-based or -informed approaches with youth and families specifically: trauma-informed care and a cognitively-based treatment (e.g., Trauma-Focused Cognitive Behavior Therapy [TF-CBT], Dr. Ross Greene's model: CPS, now called: Collaborative & Proactive Solutions)
- » Using persistence and creative individualized approaches to challenges a youth might be experiencing that impact their ability to be in the home such as: using TF-CBT in the location where the youth had been abused and helping the youth to redecorate the space which was very healing; or staff available 24/7 while a youth is having home time even if it means the worker is sitting in their parked car located nearby. Whatever it takes to help the youth and family feel safe
- » Establishing Family Education Day with families determining what is needed/what the focus should be
- » Beginning discharge thinking before the admission occurs and actively planning once the youth is admitted
- » Contacting the outpatient Doctor to ensure seamless "handover" of care
- » Addressing parent's mental health needs and providing basic assistance (transportation, gas, groceries) if needed while the youth is at the residence
- » Actively incorporating culture into the treatment (e.g. hiring bilingual/bicultural staff, hiring interpreters, having a telephone phone-line for linguistics, training staff on cultural comfort/humility and competence)
- » Managing risk by ensuring when staff go into the home or community they put their location and time on their work calendars so their whereabouts are well known
- » Creating Behavioral Coaches for older youth who are transitioning into the adult system to help with transition logistics, support, and community connection

PROGRAM  
EXAMPLE

## EXCELSIOR YOUTH CENTERS, INC., COLORADO

*In 2014, Susan Hébert signed on as CEO of Excelsior Youth Centers in Colorado and joined an organization that recognized that it was time for change. She acknowledged, “For nearly 43 years we were the largest traditional residential program for females in the country. But, because we were not early adapters to community-based care — we didn’t have the best reputation. We were a dinosaur agency. We were hanging on to kids, using far too many restraints, the run rate was off the charts, the acuity level was rising, and our state monitors put us on probation. We had to change.”*

And change they did. Susan and her team embarked on a multi-year strategic effort to reengineer, retool, and rebrand Excelsior. With the help of the Board, industry leaders, and an outside consultant, the organization made significant changes — quickly. Within two years, they expanded community services by 65% and transformed their traditional residential services (previously with a length of stay > 1 year) altogether. They initially shifted their programming to offer short-term residential interventions (crisis stabilization [up to 21 days]; intensive stabilization [30-60 days]. Though this

represented an improvement of direction, it soon became apparent that to survive and thrive Excelsior would need to make an even more radical break with tradition. Now Excelsior provides in-home as well as Mental Health Clinic behavioral and mental health services to youth and families; intensive treatment with foster care/kinship search [60-90 days], High Fidelity Wraparound and other innovative community-based services, and are concertedly focused on finding and engaging family for every youth they serve.

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**Susan and her team embarked on a multi-year strategic effort to reengineer, retool, and rebrand Excelsior.**

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## Essential Element 04: Practice Strategies and Tools

### Tools they put in place include:

- » Creating a new senior leader 'planner' role to map a strategic organization wide effort to train all staff on trauma, teach new skills, and use new tools
- » Identifying new evidence-based or -informed tools to teach staff, youth and families including: Dialectical Behavior Therapy (DBT), Cognitive Behavior Therapy (CBT), FFT, and High Fidelity Wraparound
- » Eliminating seclusion and implementing behavioral training to teach staff about trauma, how to recognize triggers and potential crises, and how to de-escalate difficult situations
- » Implementing Wellness Recovery Action Planning (WRAP) so each youth in care had a soothing/crisis prevention plan in place
- » Developing interdisciplinary teams to intervene and respond to crises
- » Changing their run/elopement policy (from chase/hold/restrain) to trying to do everything possible to prevent the run but if it happens, physical management is not used. By educating and giving more responsibility and decision making to the youth and working with the families, the run rate and injuries to youth and staff greatly decreased.
- » Increasing cultural and linguistic competency education and training which was especially important for home-based care
- » Becoming intentionally family focused and developing educational opportunities for families being served in the residential program or at home



**“I could only speak to my Mother for 5 minutes a week but my mental health counselor made sure that it happens more often. If something happened on the floor, even if it was not my fault, I could lose my phone call.**

**My Mother is the expert on her child – that’s me!”**

*name withheld*

Essential Elements of Short-Term Residential Intervention

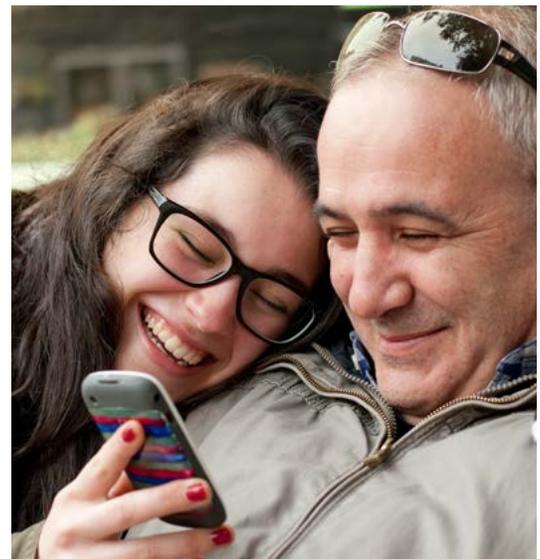
ESSENTIAL  
ELEMENT  
05

## Using Data to Inform Practice

*In an era of fiscally prudent, accountability-focused, outcome-driven health care service delivery, residential providers must actively collect, use, and share data within the organization and externally as a tangible demonstration of residential intervention effectiveness. Data are the guidepost for changing practice, measuring the effect and answering the fundamental questions, “Are we making a difference? Are we making a difference for everyone? Are we improving the lives of those we serve? Are some demographic groups succeeding better than others? How do we know?” Residential providers without data to support their work will not succeed in the current or next generation of service delivery.*

### ACTION SNAPSHOT

- RECOGNIZE DATA IS ESSENTIAL TO EFFECTIVE SERVICE DELIVERY AND VIABILITY.
- IDENTIFY METRICS TO USE.
- USE DATA TO DRIVE CHANGE IN THE ORGANIZATION.



## COMMON TASKS

- » Recognized data are essential to tell the story of the organization
- » Sought out new methods and technology to advance data reporting and collection
- » Solicited input internally and externally on metric priorities
- » Communicated key performance indicators across the organization
- » Shared key performance indicator data and other data elements internally and externally
- » Translated data and reported on the data in terms of the impact on youth and families served, paying particular attention to any disparities by race, ethnicity or culture
- » Developed/used both objective and subjective measures of service effectiveness
- » Adopted data transparency and used the “good and the bad” data to facilitate quality improvement
- » Established ambitious organizational/service goals
- » Embedded objective measures into a Strategic Plan and used the data to report on results of the change efforts
- » Used data to identify training needs and areas for quality improvement

Recognize data is essential to effective service delivery and viability. Identify metrics to use. Use data to drive change in the organization.

PROGRAM  
EXAMPLE

## FAMILY SERVICE OF RHODE ISLAND

*Family Service of Rhode Island is one of the state's oldest and largest human service and education non-profit organizations and is committed to getting children and youth where they need to be as quickly as possible. It is a comprehensive social service organization that manages through thoughtful coordination and a shared vision, many programs throughout Rhode Island, providing essential resources for individuals, families and communities that are underserved.*

According to Jennifer Etue, the former Clinical Administrator for Children's Services, "We are guided by our vision to transform the quality of life and overall health of communities by working to break the cycle of poverty, disease discrimination and lack of opportunity." By forming effective partnerships, building on what works, using contemporary treatment approaches, and connecting their work with other initiatives, the agency is playing a leading role in the Department of Children, Youth and Families System of Care by using a model based on Wraparound Milwaukee and focusing on shorter lengths of stay across their system. The organization is implementing several evidence-based programs in their organization and residential services including: Safe Start, TF-CBT (adapted for child welfare), Strong Families Strong Forces through the National Child Traumatic Stress Network (NCTSN), and Alternatives for Families: CBT and Child-Parent Psychotherapy through a NCTSN grant.

In addition, Family Service of RI is rolling-out Trauma Systems Therapy as part of a NCTSN grant, building on earlier work with Dr. Glenn Saxe (from New York University's Langone Medical Center), in their residential services with the goal of creating small, home-like settings serving 5-8 youth per site. With ambitious goals to reduce length of stay (Short-term Assessment and Diagnostic Center: 7-10 days and Residential: 30-90 days) and improve outcomes the organization has focused on trauma; bolstered training (such as Think Trauma training), weekly supervision and crisis support for staff; and emphasized parental support, engagement and home-based work by integrating residential and community-based services (home-based team involved during and after residential). The organization has also focused on engaging youth, siblings, and service system partners (e.g. the courts, state agencies, public schools) to enhance service success.

## Essential Element 05: Using Data to Inform Practice

**Given their multi-modal efforts, Family Service of RI is using a variety of methods to monitor their data and improve practices, including but not limited to:**

- » Seeking out external consultation and participating in a national organization's "Residential Transformation Change Cohort" to improve their outcomes
- » Collecting and contributing post-residential discharge data (e.g. recidivism, length of stay, decrease use of psychiatric medications, hospitalizations) to an external consultation project
- » Collecting data on fidelity to the models being used
- » Measuring family engagement to ensure it happens as quickly as possible
- » Using standardized tools to assess the impact of their work (e.g. the Child and Adolescent Needs and Strengths tool)
- » Using a youth self-assessment tool to monitor, support and adjust their work with the youth and family. The family worker and staff also have a self-assessment process to determine how things are going.



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**“We are guided by our vision to transform the quality of life and overall health of communities by working to break the cycle of poverty, disease discrimination and lack of opportunity.”**

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PROGRAM  
EXAMPLE

## WARWICK HOUSE, PENNSYLVANIA

*About 14 years ago, Jeff Friedman began a family-intensive child & adolescent residential program, for ages 5-15, adapted from the REPARE (Reasonable Efforts to Permanency through Adoption and Reunification Endeavors) model initially developed and successfully implemented at Four Oaks in Iowa (1995-1998); funded by the National Institute of Health and the Annie E. Casey Foundation.*

The primary goal of the Iowa REPARE family-centered model was to decrease the current length of stay for residents from 18-36 months to 7-9 months. The model was highly successful but was not sustained after grant support ended. Warwick House was purchased and the new owners supported Dr. Friedman's commitment to create a residential treatment center in the Philadelphia area that was dedicated to family reunification and intensive family treatment. They supported Dr. Friedman's replication of the REPARE model. Dr. Friedman approached Magellan Healthcare, Inc., their managed care entity, and successfully received their fiscal support. With consent and tireless support from REPARE clinicians, in particular Kelly Malone at Four Oaks, researchers and previous funders, Warwick House used the training manuals and materials and replicated the model which is clinically driven, outcome-oriented, and focused on working with the family (see Landsman et al. references). The goal of treatment is to shift the perception of all involved from

“placement of last resort” to “placement for growth and change.” So, rather than placement being seen as failure, it is seen as a new opportunity for families to restore equilibrium and develop healthier and more effective ways to function.

With additional implementation experience and by: studying current residential intervention literature; using a variety of evidence-based and evidence-informed treatment approaches; and providing intensive training, clinical, and supervisory supports, Warwick House replicated the reduced length of stay (less than six months) and went further. They decreased hospitalizations/recidivism and reduced length of stay to approximately four months by adding intensive filial case management and home and center-based eco-systemic family therapy twice per week. In addition, 85% of the youth reunified with their family and went on to therapeutic foster care or adoption.

## Essential Element 05: Using Data to Inform Practice

### Warwick House has also focused on:

- » Assessing the unique needs and intergenerational histories of the youth and families they serve
- » Treating the prevalence of trauma in particular intergenerational trauma in a safe trauma informed setting
- » Specializing in the needs of adopted youth struggling with problems of complex trauma and attachment issues
- » Identifying direct care staff as Reactive Attachment Disorder specialists
- » Reducing caseloads of therapists in order to effectively serve youth with severe cognitive, emotional and behavioral symptomatic issues linked to deeper filial issues
- » Providing data to funders (e.g. Magellan) to track and monitor outcomes (family & individual sessions, ancillary contacts, admissions to 24-hour levels of care, community resources utilized, Child and Adolescent Needs and Strengths (CANS), etc.)
- » Grounding treatment in an innovative, intensive, eco-systemic, family based model (family therapy and parent training) that blends center-based with ongoing strategic home-based treatment backed by demanding clinical supervision
- » Providing intensive filial case management which attends to the needs of the caregivers so that they reach their potential to attend to the presenting issues of their child
- » Offering strategic post-discharge clinical in-home support (directly to the family) and community-based support (in collaboration with the recommended services, e.g., family based team) to assure a successful transition to the home, which is the primary goal. Post discharge support varies by program and is based on clinical need and can be provided up to a year beyond discharge.



The goal of treatment is to shift the perception of all involved from “placement of last resort” to “placement for growth and change.”

Essential Elements of Short-Term Residential Intervention

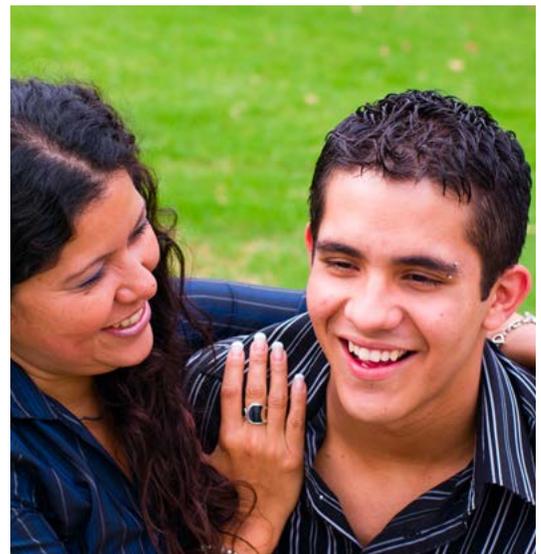
ESSENTIAL  
ELEMENT  
06

## Quality Improvement: Learning What Works

*Successful residential providers know that in order to remain relevant within the industry and to those they serve; they must aspire to be a high quality, high-reliability organization providing “consistent excellence,” and not accept sub-standard service provision (Agency for Healthcare Research and Quality, 2016; Chassin, 2017). To achieve this, providers must continually study their services, consider and implement new methods and approaches, and assess the needs of the youth, families, staff and organization. At the same time, threats to effective residential intervention form the basis of continual quality improvement – learning what works, what does not work, and what must change. In short, effective quality improvement requires “consistent mindfulness” (Chassin & Loeb, 2013).*

### **ACTION SNAPSHOT**

- DEVELOP VIGILANCE ON KEY QUALITY INDICATORS. RECOGNIZE THREATS TO ENGAGEMENT, TREATMENT, AND PERMANENCY AS SENTINEL EVENTS.
- CREATE MECHANISMS FOR IMMEDIATE COURSE CORRECTION.



## COMMON TASKS

- » Used data to measure youth/family engagement and progress while in the residential intervention (e.g. permanency scale or no permanency plan developed)
- » Used data post-residential intervention to assess effectiveness (e.g. recidivism, functioning at home/school/community)
- » Used data for organizational benchmarking over time
- » Greatly reduced or stopped the use of restraint and seclusion because these practices derailed treatment and created more conflict and harm
- » Included a robust debriefing practice for all incidents
- » Faded and stopped using point and level systems because they caused conflict, were inconsistently used, did not teach important behavioral skills, and did not generalize to home/community settings
- » Sought accreditation from a recognized standard-bearing organization to continually focus on quality and advancing practice
- » Engaged youth and families in quality improvement projects (e.g. environmental changes, policy revisions, external audits, etc.)
- » Brought in external consultation for independent organizational assessment or clinical practice review purposes
- » Developed expertise within a practice element and advanced the greater systems' knowledge and practice through study, publication, and professional presentations
- » Acknowledged that statutory, regulatory and policy standards were minimum practice expectations and continually sought to surpass these requirements

Develop vigilance on key quality indicators. Recognize threats to engagement, treatment, and permanency as sentinel events. Create mechanisms for immediate course correction.

PROGRAM  
EXAMPLE

## CATHOLIC CHARITIES, MARYLAND

*Catholic Charities in Baltimore, Maryland felt the pressure to reduce lengths of stay and improve long-term outcomes for children and families. They felt pressure externally from child welfare and mental health. They felt pressure internally from their own ranks who wanted to be ahead of the short-length-of-stay curve and stay relevant in the industry.*

Their leaders, Michael Dunphy, Mark Greenberg, Ezra Buchdahl, and Patrice Flagle capitalized on a 1915c Psychiatric Residential Treatment Facility demonstration waiver and created a pilot program to focus on family engagement. The pilot approach allowed them to test the new orientation and invite staff and partners into the process in order to be part of the wave of change for better outcomes for youth and families. Their team of administrators, clinical leaders, and legacy parents studied the literature to learn what supports treatment success and contributes to post-discharge failure. They also studied other provider efforts like Warwick House. From there, they began to make meaningful changes to produce better outcomes for youth, families and staff. They

acknowledge the process, “*was not all unicorns and rainbows*” and hard decisions had to be made to create quality and service improvement.

After one year of home-based residential intervention implementation, Catholic Charities contracted with the University of Maryland School of Social Work Innovations Institute to conduct an independent evaluation of their home-based residential pilot and compare the findings to the outcomes of those served in their traditional residential center. Using the CANS tool, youth and families served in the home-based pilot program demonstrated greater improvement in wellbeing, impact, and needs domains compared to the control group.

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**“Training never ends. It is a journey.  
We learn something new from each family with  
which we work — they, too, are our teachers”**

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## Essential Element 06: Quality Improvement: Learning What Works

### Some of the changes that fostered these better outcomes included:

- » Ensuring families attend a weekly multi-family group meeting (“Family Night”) that provides clinical, educational, and support. Family night includes legacy parents who provide information, reassurance and hope.
- » Providing transportation to support family participation, especially for family night
- » Ensuring youth go home every weekend. Going home is not behavior-driven (safety-driven) – it is a right. *“The goal is to help parents make the adjustment necessary to deal with life...it won't be perfect.”*
- » Eliminating “home visit” from their language
- » Ensuring their diverse workforce is receiving continual training, close supervision, and support
- » Training in cultural and linguistic competency is ongoing in order for staff to be prepared to work across the cultural spectrum and understand and respect the culture of the family they are working with – particularly when working in the home or community. *“Training never ends. It is a journey. We learn something new from each family with which we work – they, too, are our teachers.”*
- » Recognizing the family as the experts and teaching staff their job is to *“graft on to the family systems' team”*
- » Realizing that transformation to short-term care means the program must continually develop and change and therefore recognizing when strategies or programming elements no longer contribute to success or create barriers to achieving goals and embracing new, innovative approaches to partnering with others. *“Like training, program development never ends.”*
- » Deploying program staff to the family’s home to teach strategies while youth are at home
- » Shifting from the perspective that “placement = treatment”, *“Kids don't live with us, they come to us for treatment. They are visiting us and still living at home and going home every weekend.”*
- » Extending post-discharge follow-up from six months to one year and having the Family Support Specialist conduct the telephonic follow-up
- » Creating a position that is solely focused on discharge
- » Seeking real-time feedback from families, both formally (through surveys) and informally, so issues can be addressed as they occur – including how the partnering is going with the team as a whole and those working individually with them in the home
- » Recognizing that *“treatment is not over when youth/families are discharged. . . a certain stage of treatment is over, but treatment overall is not”* so creating emergency and planned respite and some degree of crisis response for home post-discharge are important components. Equally important to ensure that the child and family are connected to aftercare treatment (e.g., outpatient mental health treatment, individual/family therapy, psychiatric care) and that services are arranged prior to discharge to minimize delays in service start times.
- » Understanding that with shorter lengths of stay, which is a primary goal, youth and families may need a periodic “tune up” that could lead to a return to the program. If that happens, it is not viewed as a “failure” but an opportunity return to prior levels of success while continuing to strengthen resiliency.

PROGRAM  
EXAMPLEEPWORTH CHILDREN AND  
FAMILY SERVICES, MISSOURI

*In 2005, Kevin Drollinger (former Chief Executive Officer), Susan McDowell (Chief Program Officer) and their team at Epworth Children and Family Services in Missouri decided it was time to reinvent their approach to residential service.*

*“We had the notion that residential services were peaking and the trends were toward community-based care. We also heard the notion that residential should be treatment – not a placement. So, we made the decision to grow our community-footprint, merge with other services, and become very intentional. We were driven by the philosophy of keeping youth home- and community-connected and we knew in order to survive we had to change our business and practice models.”*

With consultation support from the Alliance for Strong Families and Communities, Epworth began the process of making these notions a reality. Their work was guided by strategy and informed by David La Piana’s, *“The Nonprofit Strategy Revolution: Real-Time Strategic Planning in a Rapid-Response World”* with a particular focus on real-time issues and continual strategic adjustment. More than 80% of the staff were involved in strategy development and had a role in the change process as did the Board. The Epworth team refocused on the organizations’ mission, *“To help children, youth and families move toward self-sufficiency by focusing on health, housing, education and employment”* and created a Strategy Map, Balanced Scorecard (program outcome report cards), Strategy Screen questions (11), and a Zimmerman Chart (Matrix Map).

Key to their transformation was inculcating a culture of quality improvement, educating staff, and not creating a culture of “gotcha.” Also, important in their change process was

recognizing Youth Advisors’ (direct care staff) grieving process of letting go of old methods (e.g. level system) and embracing a new direction. Leaders called this process, “Grinking” (growing and shrinking at the same time).

To aid the shift in culture and practice, Epworth also adopted, “Top Grading” with their staff (e.g. “A” = star employees; “B” = new to a role, do the job but do not take initiative yet, “C” = staff who underperform and create disarray). Now, A and B employees are moved up in the organization more quickly and subpar C employees are more readily helped out the door to a better career fit.

Epworth also changed how they hire staff. They are more purposeful now. Interviews are behaviorally oriented and include scenario discussions. They use behavioral core competencies to assess/evaluate staff, and use core competencies to create staff development plans as necessary.

Since 2005, residential capacity at Epworth has decreased residential capacity from 46 to 29 beds and quality improvements have been realized, such as: reduced restraint use (-82%); reduced seclusion use (-95%); and reduced runs/elopements (-76%). Other positive outcomes include 76% youth demonstrate improvement in severity of psychiatric symptoms and 73% demonstrate improved connections and community supports.

## Essential Element 06: Quality Improvement: Learning What Works

### Other quality improvement activities that supported their transformation include:

- » Defining “success” so meaningful data can be captured and tracked
- » Creating an organizational dashboard to measure and track youth outcomes, family outcomes and impact outcomes
- » Developing metrics and an outcome spreadsheet that aligns with the organization mission: health, housing, education, and employment
- » Tracking successful youth movement to less restrictive service (currently 71%)
- » Increasing the capacity for successful transition by having the youth/family’s therapist in the residential program follow them when they return home/to the community
- » Rewriting all residential program policies and procedures for value and practice consistency
- » Developing new (2016) quarterly measures for trauma and psychiatric symptoms
- » Implementing an ecomap for youth (visual assessment tool to highlight relationships)
- » Implementing a new Diversity and Inclusion Committee structure, training, and incorporated diversity and inclusion into the leadership retreat(s) and the Annual Meeting



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“We made the decision to grow our community-footprint, merge with other services, and become very intentional.”

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Essential Elements of Short-Term Residential Intervention

ESSENTIAL  
ELEMENT  
07

## Fiscal Strategies

*Committing to residential transformation in order to achieve sustained positive outcomes for youth and families requires leaders to critically examine their bottom line and use the power of their budget to create this important change. Financing strategies also require support — whether it is approval for budget reallocation from Boards of Trustees, identification of new/additional fiscal resources from funders/oversight agencies, a shift in state/federal Medicaid reimbursement, or soliciting grant or private funding. Regardless of funding source, “. . . the stability of the financing has enormous impact on both the scope and success of the various efforts” (BBI, 2011).*

*Five categories of common fiscal strategies to implement transformative change were recently identified (BBI, 2011). They include: 1) Medicaid waivers and expanded use of Medicaid, 2) performance-based/incentive contracting, 3) reallocation of existing funds, 4) private funds, and 5) reinvestment strategies (BBI, 2011). Specific detailed information about each of these strategies along with several program examples and contact information for example program leaders are available at the BBI website (Resources - White Papers section). The reader is directed to the Fiscal Strategies document for additional information: [http://www.buildingbridges4youth.org/sites/default/files/BBI\\_Fiscal%20Strategies\\_FINAL.pdf](http://www.buildingbridges4youth.org/sites/default/files/BBI_Fiscal%20Strategies_FINAL.pdf)*

### ACTION SNAPSHOT

- DEVELOP CREDIBILITY WITH FUNDERS.
- HOLD FIRM TO VALUES-BASED GOALS AND PREPARE TO CUT ANYTHING.
- THINK CREATIVELY AND FLEXIBLY.



## COMMON TASKS

- » Used the power of the budget to make the desired change by re-directing funds
- » Identified/clarified what was important to the organization and invested in it such as after care, decreased workloads so staff can work in the family's home, hired family advocates, increased family engagement and support, and increased training in clinical practices
- » Sacrificed 'sacred fiscal cows' if needed
- » Created flexible funds to cover concrete supports for families: a) during the residential intervention to be able to visit, stay connected and reunite as quickly as possible; and, b) after the residential intervention to sustain outcomes post-discharge
- » Sought new funding and/or fundraised for such activities as testing/evaluating new model/approaches, implementing evidence-informed and evidence-based practices with fidelity, and tracking positive sustained outcomes post-discharge
- » Created new service lines when necessary complimentary services did not exist
- » Worked with funders to elicit their support for budget flexibility and/or adjusting the rate
- » Pilot tested new approaches; tracked outcomes to show it worked, and then went to funder for fiscal support

**“The fiscal strategy that we used the most, was making the decision to invest in what we believed was needed (after care, family support, family advocates, flex funds). Yes, that meant we had to eliminate others costs that many thought were important, but to us, these investments were most important — what we wanted to do, and making decisions about what we had that could allow for it. We didn’t wait around. We wanted these things and then decided what to cut and then we invested in it.**

**If you don’t invest in it, it’s probably not important to you anyway. Once you know what is important to you, you make choices to make those things happen. If you are the CEO, there are tons of choices you can make to create the financial structure for this to happen. If you are complaining about finances for this, I would question your commitment to making this happen. If you are the CEO, you have the power of the budget. And if you aren’t using your budget, you’re just talking.”**

***Jeremy Kohomban, President and Chief Executive Officer (CEO)***

# THE ROLE OF OVERSIGHT AGENCIES AND PRAGMATIC STEPS TO FACILITATE CHANGE



## SECTION FOUR

## 04

*While this Guide is primarily intended to focus on steps residential providers can take to implement effective short-term residential interventions this work cannot be done in isolation.*



Oversight agencies and systems (including states, counties, cities, insurance companies, etc.) play important roles in helping residential programs transform to effective short-term services with sustained positive outcomes for youth and their families. These agencies, whether child welfare, mental health, juvenile justice, education, Medicaid, and/or Medicaid managed care plans can pave the way and lead to the desired change by using their inherent authority as funders, standard setters, and monitors for desired outcomes. They can also reset the system vision by laying the foundation for reform and improvement by recasting the intent and framework for residential intervention.

Oversight agencies from several states have begun this important work (see Appendix D for information on how to contact leaders from these states to learn about their improvement efforts). Each state approached their transformation effort differently, but leaders in the oversight agencies started this process based on the realization that traditional residential youth-centric practice was not achieving positive long-term results. In short, youth and families served were not experiencing sustainable gains in the community for as long as they and residential providers had hoped. The oversight agencies recognized that it was no longer acceptable to simply buy residential services — it was time to buy outcomes and shift the business and practice model.

The key to successful system change requires oversight agencies to focus on four essential elements: policy, practice, regulation, and fiscal. Many of these changes cross multiple elements and often require sequencing to achieve the desired change. The specific steps and methods used in each of these areas vary, but states that have successfully supported residential transformation efforts have included the elements that follow.

## Declaring a new vision, values, and financing models for residential interventions to:

- » Recognize the ideal place for youth is with their family and therefore every effort will be made to ensure youth remain in their own home whenever safely possible
- » Understand that when placement away from the family is necessary, priority will be for youth to be placed with kinship family, and if this is not available, in the most family-like setting as close to home as possible, be placed with siblings whenever possible, and reunited with their family and siblings as soon as safely possible
- » Partner with the family throughout and after the residential intervention in order to prepare the family to care for their child in the best way possible
- » Respect and treat families and youth with dignity and ensure they have an active and meaningful voice in all decisions that affect them
- » Make a commitment to ensuring that all residential and community practices are strength-based, individualized, trauma-informed, culturally and linguistically competent, family-driven, youth-guided, and develop oversight mechanisms to hold programs accountable to high standards in all of these areas
- » Ensure permanent connections with parents, siblings and other caring supportive adults is a priority focus of residential interventions for every youth pre-admission, and the most important work post-admission for youth without a permanency plan
- » Find ways to develop federal and state partnerships for funding flexibility with the system that has responsibility for oversight and decision-making
- » Explore payment structures and methodologies such as per

diem rates, case rates, risk-sharing, reinvestment strategies, blended, pooled or flex funding and leveraging Medicaid dollars to the fullest extent possible

- » Find new ways to finance services that does not reward providers for keeping beds filled and may incentivize them to create new services that support positive sustained outcomes for short-term residential interventions while creating alternative services to prevent unnecessary residential interventions
- » Ensure that Medicaid rules allow youth spending as much time as possible with families throughout the residential intervention
- » Ensure that funding covers residential staff working in the homes and communities of families
- » Fund aftercare services that will support the youth and family in the community with the same child and family team that supported them during the residential intervention

## Developing strategies and creating expectations to:

- » Recognize the ideal place for youth is with their family and therefore every effort will be made to ensure youth remain in their own home whenever safely possible
- » Understand that when placement away from the family is necessary, priority will be for youth to be placed with kinship family, and if this is not available, in the most family-like setting as close to home as possible, be placed with siblings whenever possible, and reunited with their family and siblings as soon as safely possible
- » Partner with the family throughout and after the residential intervention in order to prepare the family to care for their child in the best way possible



“Be relentless. . . with staff, families and the state. . . be willing to fight and beg for money. The pace is faster, the urgency is more, so the fight can be tougher — you are challenging tradition.”

*Kevin Keegan, Catholic Charities*

- » Respect and treat families and youth with dignity and ensure they have an active and meaningful voice in all decisions that affect them
- » Make a commitment to ensuring that all residential and community practices are strength-based, individualized, trauma-informed, culturally and linguistically competent, family-driven, youth-guided, and develop oversight mechanisms to hold programs accountable to high standards in all of these areas
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outcomes for short-term residential interventions while creating alternative services to prevent unnecessary residential interventions

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- » Ensure that funding covers residential staff working in the homes and communities of families
- » Fund aftercare services that will support the youth and family in the community with the same child and family team that supported them during the residential intervention

## Using data, tools, techniques and approaches to:

- » Understand and be knowledgeable about what data to collect, when to collect the data, how to assess the reliability of the data, and how to use the data to inform the oversight agencies and the provider-community on the results being achieved in all aspects of the system and ensure decision-making will be outcome-based, resource-driven, and continuously evaluated for improvement

- » Create procedures for public agencies to use assessment tools with common domains immediately upon the youth's entrance into care to determine the appropriate treatment needs and level of care indicated
- » Create procedures for identifying youth who have been in a residential intervention for three months or longer, determining the reasons each youth remains in a residential intervention, and developing a plan for each youth to transition to a less restrictive, more family-like setting
- » Create procedures of identifying youth who have been in a residential program for one month and no identified permanency plan has been identified, creating mechanisms to bring representatives from all agencies involved with the youth to immediately support work in this area
- » Encourage the use of evidence-based or evidence-informed practices that are culturally-congruent, responsive and consistent with the ethnic and cultural background of the youth and families served and support sustained positive outcomes post transition and discharge from the residential intervention. Put a strong emphasis on sustained post-discharge outcomes for all practices, and expect providers using practices with only evidence of youth 'getting better in care' and no evidence of long-term outcomes to change or prove the efficacy of their practice approaches
- » Continually search for better practices and learn from other change and reform efforts across the country that can expand the service array available to youth and their families
- » Review licensing standards to ensure they create meaningful, reasonable standards for residential interventions and do not create barriers to desired practice while helping to promote client and family rights, quality improvement, staff competence, and consistent practice among providers
- » Review contracts regularly to ensure that meaningful and reasonable requirements are in place that do not create barriers, impediments, or unfunded mandates in the desired work to be performed and allow placed youth to spend time at home (or at a foster home if not yet returning home) developing the skills needed to successfully live with their family and in their community without creating artificial barriers e.g. number of days allowed
- » Use performance-based contracting that ensures providers are appropriately reimbursed for achieving desired outcomes over time and incorporates penalties if not achieved

All of the initiatives to transform residential service are multi-year projects that were begun with the recognition that this work was not a quick-fix to change one dimension of care (e.g., length of stay) but instead was a systemic change process that would take several years of diligent, focused attention to achieve the desired effect. Each initiative made change incrementally (e.g. reduced length of stay from 9 months to 6 months and then 3 months) and recognized this is not the work of one. It takes a dedicated team of oversight agency leaders with youth, families, advocates, educators, funders, and provider leaders who commit to the new direction and stay the course — despite continual challenges (budget cuts, staff turnover, situational crises, etc.).

# CONCLUSION

More than twenty well-known organizations from across the United States contributed to this Guide. Each demonstrated innovative, transformative change in how they implemented short-term residential intervention to achieve positive outcomes for youth and families. Their experience is compelling evidence that fundamental practice change is possible and happening. Moreover, these providers operationalized: residential inversion – where residential services are being delivered in the home and community with youth and families – and youth and family roles, perspective, needs and preferences are being infused into residential service delivery. This fundamental reorganization of established methods of service delivery is redefining the future of residential intervention and resulting in pragmatic outcomes that meet the needs of those served.

Practice and business models are shifting as are expectations from standard-bearing organizations, federal and state leaders, national organizations, trade associations and providers are declaring that the status quo and residential business as usual is no longer acceptable. Health care is following the path other industries have taken toward “high reliability” service. Failure is not acceptable. Industry standards are advancing the BBI values, principles and approaches in areas of necessary change – specifically partnership and engagement with families, youth, providers and key stakeholders.



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Courageous leaders can begin their own journey of change by reading this material, pursuing the resources and references provided, beginning the dialogue with staff, youth and families-served, and reaching out the Contributors who participated in the development of this Guide.

**There is no perfect process. Mistakes will be made along the way — embrace them.**

Today's challenges and missteps will lead to tomorrow's innovations, improved practice, and an investment in the new methods derived from the process, as well as a renewed commitment to sustained positive outcomes for youth and families served.

These providers affirm that short-term residential intervention is imperative and can produce positive outcomes but requires key ingredients to effect this important change:

- » A strong commitment to the importance of seeing youth in the context of their family within a home and community setting. For youth without identified family, a strong commitment and urgency to family-finding and creating permanency for every youth
- » A relentless drive to provide the best service possible to youth and their families
- » A willingness to let go of the status quo
- » A clear recognition that data, data transparency, and using data to advance change is not only desirable, it is mandatory
- » A frank appreciation that longer lengths of stay in residential intervention can produce iatrogenic effects, create more disruption to youth/family connections, thwart permanency, and has no evidence to support sustained positive outcomes
- » A keen understanding that leading to the many dimensions of transformative change identified in this Guide requires leadership passion, zeal, and conviction that youth-guided, family-driven intervention must be attained
- » Cultural and linguistic competency for every organization, staff, and persons-served is an important driver of meaningful change toward cultural understanding, respect, humility and comfort
- » The only 'sacred cow' in the transformation process is the commitment to full and meaningful inclusion and empowerment of youth, families, staff, and service partners
- » To reduce residential intervention lengths of stay requires family inclusion and integration with home and community-based services
- » The shift to short-term residential intervention cannot be done in isolation and requires strong partnership and support from funders, regulators, and other key community constituents (e.g. schools, courts)

# RESOURCES

# RESOURCES

## TRANSFORMATION RESOURCES AND TOOLS RECOMMENDED BY LEADERS INTERVIEWED

Alliance for Strong Families and Communities: “Leading Cultural Adaptation Toolkit: A Toolkit of Thought and Belief Tools for Child and Family-Serving Organizations” available at: <http://registration.alliance1.org/pubs/leading-cultural-adaptation-toolkit>

Blau, G.M., Caldwell, B., Lieberman, R.E., (Eds.). (2014) Residential Interventions for children, adolescents and families: A best practice guide. New York, NY: Routledge.

Building Bridges Initiative: <http://www.buildingbridges4youth.org>

Connecticut Behavioral Health Partnership Literature Review (2009, April). Child and Adolescent Residential Treatment Programs: A Review of Average Length of Stay (ALOS) and Factors Effecting Length of Stay. Retrieved on June 17, 2016, [http://www.ctbhp.com/reports/CT\\_BHP\\_Literature\\_Review-Residential\\_Treatment.pdf](http://www.ctbhp.com/reports/CT_BHP_Literature_Review-Residential_Treatment.pdf)

Magellan Lehigh Valley Care Management Center, One-Year Outcomes Report Short-Term Residential Treatment Facility, Pilot Program (2010), available at: [http://www.magellanofpa.com/media/157075/lehigh%20short%20term%20rtf\\_final.pdf](http://www.magellanofpa.com/media/157075/lehigh%20short%20term%20rtf_final.pdf)

National Coalition for Child Protection Reform (2009). *Residential treatment: What the research tells us*. Retrieved on June 17, 2016, <http://www.nccpr.org/reports/residentialtreatment.pdf>

The Ontario Centre of Excellence for Child and Youth Mental Health has a number of resources and services available to support agencies with implementation, evaluation, knowledge mobilization, youth engagement and family engagement. Retrieved on February 7, 2017, <http://www.excellenceforchildandyouth.ca/what-we-do>. Other resources are available at Centre’s resource hub at: <http://www.excellenceforchildandyouth.ca/resource-hub>.

Six Stages of Family Finding by Kevin Campbell, available at: <http://www.afamilyforeverychild.org/Activities/Oregon/FamilyFinding/FAMFSteps.pdf>

Strengthening Children’s Mental Health Residential Treatment through Evidence and Experience (2015). Kinark Child and Family Services Position Paper. Retrieved on January 4, 2017, <http://www.kinark.on.ca/wp-content/uploads/Strengthening-Childrens-Mental-Health-Residential-Treatment-Through-Evidence-and-Experience.pdf>

TCOM Conversations (2016, December): The Role of the CANS in Reducing Residential Treatment Placement and Length of Stay in New Jersey. TCOM Conversations is jointly hosted by Chapin Hall at the University of Chicago and The Praed Foundation. Retrieved on February 6, 2017, <https://tcomconversations.org/2016/12/06/the-role-of-the-cans-in-reducing-residential-treatment-placement-and-length-of-stay-in-new-jersey/>

## BOOKS ON CHANGE LEADERSHIP

- Switch by Chip and Dan Heath: <http://heathbrothers.com/>
- Immunity to Change: How to Overcome It and Unlock the Potential in Yourself and Your Organization by Robert Kegan and Lisa Laskow Lahey

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# APPENDICES

APPENDIX  
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APPENDIX  
C

## Essential Elements Chart

ESSENTIAL ELEMENT	ACTION SNAPSHOT
Effective Leadership	Honestly self-assess. Prepare for change. Mobilize.
COMMON TASKS	

- » Studied their data (e.g.: population needs, cultural and diversity needs, service needs, community needs, organizational culture, outcomes by service, recidivism); researched and read current residential intervention literature; and conducted a gap analysis of what was missing (e.g. to improve positive outcomes post residential service; to shorten lengths of stay; to successfully move from a youth-centric to family-centric treatment and support model; to support staff in working with families in the community; to more effectively partner with community providers and the natural family support systems)
- » Created a new vision (e.g. as above) and plan for change with a specific goal(s)
- » Educated and involved their Board and staff and got support and buy-in to a new residential intervention model
- » Formed a steering committee with staff “champions” at all levels of the organization and implemented cascading communications model to promote the change
- » Implemented weekly accountability mechanisms to ensure effective care for every youth and family and rigorously self-audited for effectiveness or lack thereof (e.g. review of medical records and acuity indicators [restraint/seclusion/elopement/critical incidents])
- » Actively engaged system collaborators (e.g. funders, regulators, judicial partners, community providers) and youth and families in the self-study, planning and implementation process
- » Adopted a customer service orientation with youth, families, funders, oversight agencies, and community service partners (*“The customer is always right”*)
- » Expanded services or collaborated with others to ensure community supports were available to support youth and families in the home/community
- » Created the tools and resources to promote the change
- » Held tightly to the new vision and new goals despite resistance and challenges

ESSENTIAL ELEMENT	ACTION SNAPSHOT
Family & Youth Engagement and Inclusion	Philosophically commit. Embrace transparency. Engage families and youth as valued partners.
<b>COMMON TASKS</b>	

- » Committed to family inclusion – no matter what. Used Family Finding / Family Search and Engagement strategies to ensure each youth had family identified and involved
- » Engaged family and youth in an array of activities: focus groups, planning efforts, ongoing committees, and advisory councils
- » Invested in parent engagement (e.g., money for transportation for youth to spend frequent [daily, multiples times/week] time at home; resources for interpretation/translation services; and providing parent education opportunities preferably in the families' homes/communities)
- » Created new roles and hired culturally diverse family and youth advocates, family leaders, family partners, family liaisons, etc.
- » Brought culturally diverse family members and youth/young-adult graduates onto the Board of Trustees and governing bodies
- » Critically re-examined and changed policies, procedures, protocols and practices that were not consistent with family-driven, youth-guided and culturally and linguistically competent practices
- » Recognized youth and family members as co-experts and involved them in new-hire interviews, orientation classes, ongoing workforce education and trainings, quality improvement activities, liaison efforts with other families, and serving on the agency Board
- » Created open-door policies: no restrictions on calls between youths and their families (in fact, encouraging calls multiple times per day), encouraging youths' spending time at home frequently, welcoming families on site any time, (unless court-ordered)
- » Provided as much intervention in the home as possible: pre-admission meeting, service planning/treatment reviews, initial assessment, ongoing treatment, follow-up and outreach/support post-transition from the program
- » Hired culturally diverse clinicians to reflect the community being served who had previous experience working in the community/family homes
- » Expanded treatment interventions for youth and families, e.g., trauma assessment, motivational interviewing, occupational therapy, and taught families' the same skills that direct care staff were taught (e.g. crisis prevention strategies, verbal de-escalation, self-calming/soothing techniques)

ESSENTIAL ELEMENT	ACTION SNAPSHOT
Workforce Development	<b>Value workforce. Value supervision. Value culture and diversity. Change hiring, training, and practice approaches.</b>

**COMMON TASKS**

- » Prioritized and actively incorporated diversity and culture in all aspects of residential operations and workforce education
- » Deliberately recruited, mentored, and supervised a diverse workforce representing the families and youth served
- » Changed staff hiring approaches: included youth and families in job description review/development, interviewing questions and process, and education/orientation
- » Changed staff education framework: increased time and changed approach to: orientation, probation, mentoring, pragmatic skill development
- » Changed staff performance evaluation process, solicited input from youth and families and conducted “360 reviews” (staff reviews their supervisor/leadership) from other staff
- » Solicited staff perspective of training needs to successfully engage and work with families in their homes and communities
- » Prioritized supervision as an essential workforce engagement strategy
- » Enhanced supervision frequency, modality, and time allocated (e.g. minimum of weekly supervision using multi-method individual and group approaches, often doubling the amount of time)
- » Supported staff creativity to seek out innovative solutions, and new methods for youth and families, and/or teach youth a particular talent/interest they may have (e.g. music, gardening, foreign language, etc.)
- » Taught staff, youth and families dispute resolution, negotiation and conflict resolution skills
- » Elevated the role of direct care staff to work as a team with program therapists and/or provide training
- » Recognized some staff cannot make/implement intervention changes and need to be moved on to another role, setting, or career path

ESSENTIAL ELEMENT	ACTION SNAPSHOT
Practice Strategies and Tools	<b>Identify pragmatic tools and strategies for staff, families, and youth to use in the residence, community, and at home to ensure success, permanence and prevent recidivism</b>

**COMMON TASKS**

- » Used a tool to assess the level of service need was consistent with the service being provided to ensure the “right service at the right time for the right amount of time”

- » Conducted active pre-admission work and developed a 'pre-admission plan' with youth and family-identified treatment goals and support needs, specific indicators of success, and readiness for transition
- » Created urgency regarding permanency and made the first task of residential intervention to ensure that every youth had a robust permanency plan that included lifelong connections, a safe and loving home, and several permanency back-up plans in the event 'something fell apart'
- » Ensured active family engagement (including natural supports) from pre-admission through post-discharge
- » Implemented pragmatic tools to develop behavioral self-control and interpersonal management skills, e.g. taught youth, families, and staff how to mediate conflict, negotiate, and resolve disputes
- » Conducted Occupational Therapy and similar assessments to develop sensory-based strategies for self-soothing. Created pragmatic self-calming/crisis prevention and support plans to use and practice at the residential intervention and at home.
- » Used vocational assessment tools to assess youth's vocational strengths and interests in order to create a pathway to work and a career
- » Used frequent youth and family-specific progress reports (ranging from: by shift, by day, by week, by month) to ensure active engagement and progress was occurring
- » Developed bridging services to ensure youth and family are supported during residential intervention transitions (and pre-admission and post-discharge)
- » Engaged/involved community support providers in youth/family transition/discharge/post-discharge planning (e.g. developing a community support plan, using mobile crisis and crisis stabilization resources, working with the schools in advance of the transition, etc.)
- » Requested youth and families evaluate treatment during the treatment planning/review processes (not waiting until discharge to assess satisfaction) in order to create real-time course correction and ensure satisfaction and relevance
- » Close collaboration with the next level of care/service to be provided post transition and discharge (e.g. meeting together in pre-transition advance, planning the transition with the youth/family and involved agencies, planning following up and contingencies if difficulty arises)
- » Connected youth with "positive peers"/community activities and culturally-responsive social connection in their home community prior to discharge
- » Connected families to other families with lived-experience who are in the community and/or 'alumni' of the program and supported them in different ways (e.g. transportation, education events, conducting weekly multiple family groups for new and 'legacy parents' on campus with both a clinical and education component, etc.)

ESSENTIAL ELEMENT	ACTION SNAPSHOT
Using Data to Inform Practice	Recognize data is essential to effective service delivery and viability. Identify metrics to use. Use data to drive change in the organization.

**COMMON TASKS**

- » Recognized data is essential to tell the story of the organization
- » Sought out new methods and technology to advance data reporting and collection
- » Solicited input internally and externally on metric priorities
- » Communicated key performance indicators across the organization
- » Regularly shared key performance indicator data and other data elements internally and externally
- » Regularly translated data and reported on the data in terms of the impact on youth and families served, paying particular attention to any cultural disparities
- » Developed/used both objective and subjective measures of service effectiveness
- » Adopted data transparency and used the “good and the bad” data to facilitate quality improvement
- » Established ambitious organizational/service goals
- » Embedded objective measures into a Strategic Plan and used the data to report on results of the change efforts
- » Used data to identify training needs and areas for quality improvement

ESSENTIAL ELEMENT	ACTION SNAPSHOT
Quality Improvement: Learning What Works	Develop vigilance on key quality indicators. Recognize threats to engagement, treatment, and permanency as sentinel events. Create mechanisms for immediate course correction.

**COMMON TASKS**

- » Used data to measure youth/family engagement and progress while in the residential intervention (e.g. permanency scale or no permanency plan developed)
- » Used data post residential intervention to assess effectiveness (e.g. recidivism, functioning at home/school/community)
- » Used data for organizational benchmarking over time
- » Greatly reduced or stopped the use of restraint and seclusion because these practices derailed treatment and created more conflict and harm

- » Included a robust debriefing practice for all incidents
- » Faded and stopped using point and level systems because they caused conflict, were inconsistently used, did not teach important behavioral skills, and did not generalize to home/community settings
- » Sought accreditation from a recognized standard-bearing organization to continually focus on quality and advancing practice
- » Engaged youth and families in quality improvement projects (e.g. environmental changes, policy revisions, external audits, etc.)
- » Brought in external consultation for independent organizational assessment or clinical practice review purposes
- » Developed expertise within a practice element and advanced the greater systems' knowledge and practice through study, publication, and professional presentations
- » Acknowledged that statutory, regulatory and policy standards were minimum practice expectations and continually sought to surpass these requirements

ESSENTIAL ELEMENT	ACTION SNAPSHOT
Fiscal Strategies	<b>Develop credibility with funders. Hold firm to values-based goals and prepare to cut anything. Think creatively and flexibly.</b>
<b>COMMON TASKS</b>	

- » Used the power of the budget to make the desired change by re-directing funds
- » Identified/clarified what was important to the organization and invested in it such as after care, decreased workloads so staff can work in the family's home, hired family advocates, increased family engagement and support, and increased training in clinical practices
- » Sacrificed 'sacred fiscal cows' if needed
- » Created flexible funds to cover concrete supports for families: a) during the residential intervention to be able to visit, stay connected and reunite as quickly as possible; and, b) after the residential intervention to sustain outcomes post-discharge
- » Sought new funding and/or fundraised for such activities as testing/evaluating new model/approaches, implementing evidence-informed and evidence-based practices with fidelity, and tracking positive sustained outcomes post-discharge
- » Created new service lines when necessary complimentary services did not exist
- » Worked with funders to elicit their support for budget flexibility and/or adjusting the rate
- » Pilot tested new approaches; tracked outcomes to show it worked, and then went to funder for fiscal support

APPENDIX  
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## State Efforts &amp; Contact Information to Learn More

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CA	County-based residential reform	Gregory Rose, Deputy Director Children & Family Services Division California Department of Social Services 744 P Street, Sacramento, CA 95814 (916) 657-2614 Greg.Rose@dss.ca.gov
DE	Residential reprocurement using BBI principles and practices	Howard R. Giddens, Program Adm. Prevention and Behavioral Health 1825 Faulkland Rd., Wilmington, DE 19805 (302) 633-2619 Howard.Giddens@state.de.us
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MA	Statewide interagency residential reprocurement (mental health and child welfare) using BBI principles and practices	Janice LeBel Department of Mental Health 25 Staniford Street, Boston, MA 02114 (617) 626-8085 Janice.Lebel@state.ma.us  Andrea Cosgrove Department of Children and Families 600 Washington Street, Boston, MA 02111 (617) 748-2218 Andrea.Cosgrove@state.ma.us
MI	Regulatory standard review and changes include BBI principles and practices	Sheri Falvay, Director Division of Services to Children & Families MI Dept. of Health & Human Services 320 S. Walnut, Lansing, MI 48913 (517) 241-5762 falvays@michigan.gov
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