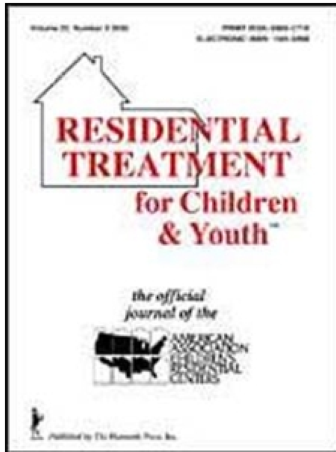
This article was downloaded by: *[Chance, Sarah]*
On: *30 April 2010*
Access details: *Access Details: [subscription number 921838143]*
Publisher *Routledge*
Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK




**Residential Treatment For Children & Youth**
Publication details, including instructions for authors and subscription information:
http://www.informaworld.com/smpp/title~content=t792306958

# Unlocking the Doors: How Fundamental Changes in Residential Care Can Improve the Ways We Help Children and Families

Sarah Chance [a]; Daren Dickson [a]; Patricia Marrone Bennett [b];Susan Stone [c]
[a] Seneca Center, San Leandro, California, USA [b] Department of Psychiatry, School of Medicine, University of California, San Francisco, San Francisco, California, USA [c] School of Social Welfare, University of California, Berkeley, Berkeley, California, USA

Online publication date: 30 April 2010

**To cite this Article** Chance, Sarah , Dickson, Daren , Bennett, Patricia Marrone andStone, Susan(2010) 'Unlocking the Doors: How Fundamental Changes in Residential Care Can Improve the Ways We Help Children and Families', Residential Treatment For Children & Youth, 27: 2, 127 — 148

**To link to this Article: DOI:** 10.1080/08865711003738522

**URL:** http://dx.doi.org/10.1080/08865711003738522

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: http://www.informaworld.com/terms-and-conditions-of-access.pdf

This article may be used for research, teaching and private study purposes. Any substantial or systematic reproduction, re-distribution, re-selling, loan or sub-licensing, systematic supply or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

*Residential Treatment for Children & Youth*, 27:127–148, 2010
Copyright © Taylor & Francis Group, LLC
ISSN: 0886-571X print/1541-0358 online
DOI: 10.1080/08865711003738522

Routledge
Taylor & Francis Group

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

# Unlocking the Doors: How Fundamental Changes in Residential Care Can Improve the Ways We Help Children and Families

SARAH CHANCE, PhD and DAREN DICKSON, MFT
*Seneca Center, San Leandro, California, USA*

PATRICIA MARRONE BENNETT, PhD
*Department of Psychiatry, School of Medicine, University of California, San Francisco, San Francisco, California, USA*

SUSAN STONE, PhD
*School of Social Welfare, University of California, Berkeley, Berkeley, California, USA*

*This article describes the organizational change effort that took place in a residential treatment facility for teenagers with serious emotional and behavioral challenges. The new service-delivery model is based on a nationwide effort to transform residentially-based services, which includes (1) short-term, intensive residential treatment with parallel community-based services to promote the youth's fastest possible return to a less restrictive setting, as well as to help parents or other primary caregivers to maintain or develop a connection with the child and prepare for the child's return; (2) aftercare services to support the stability of the child and family following reunification or transition to family-based care; (3) improvements in the service delivery decision-making pathway; and (4) better integration of residentially based services within a county's continuum of care. This new model requires programmatic changes, as well as an organizational systems and culture change, for agencies providing services to youth and families. The article documents the stages of preparing for change, the processes used to implement change and the organizational conditions that supported the change process, along with initial outcomes for the clients and their families, one year later.*

Address correspondence to Sarah Chance, PhD, Seneca Center, 2275 Arlington Drive, San Leandro, CA 94578, USA. E-mail: Sarah_Chance@senecacenter.org

*KEYWORDS residential treatment, organizational culture change, training, implementation, outcomes evaluation, residentially based services, RBS, program philosophy, adolescent, mental health, child welfare*

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

A growing number of reports have increased awareness among service providers and public policy makers of the need for a new model for serving children and youth in group homes and residential treatment facilities (All county information notice, 2008; Bazelon, 2009; Bettmann & Jasperson, 2009; Commission on California State Government Organization and Economy, 2003; Friedman et al, 2006; Knitzer, 1982; New Freedom Commission on Mental Health, 2003; Pumariega, 2007). While there is limited evidence about the trajectories of children and adolescents after discharge from institutionalized care, there is growing concern that they are likely disconnected from their natural supports, lonely, and unprepared for life after discharge (Frensch & Cameron, 2002; Hair, 2005; Miles 2007). Such concerns have become the basis of much public policy dialogue, as child welfare advocates, governmental organizations, and service-provider agencies all seek ways to improve outcomes for these youth (California Alliance of Child and Family Services, 2006; Castillo & Davis, 2007; Pumariega, 2007; Rosenblatt & Woodbridge, 2003; Stroul & Friedman, 1994; Stuck et al., 2000; California Assembly Bill 1453, 2007–2008). Broadly speaking, these calls advocate for (1) multiple levels of systems change at both policy as well as organizational and programmatic levels toward a coordinated system of care involving collaboration among the major child serving systems (e.g., child welfare, education, juvenile justice); (2) a shift from child-centered to family-centered practice; (3) accountability for measurable outcomes; and (4) ensuring that children, youth and their families have access to empirically supported interventions in the least restrictive settings possible.

The urgency to find ways to insure that young people exit out-of-home care able to hold jobs, continue their education, develop and maintain healthy relationships, and in all other ways participate as productive members of their community is also fueled by the state and national economic crisis, as local and state governments examine the cost of social service programs in relationship to their value to tax payers. Agencies providing services to youth in residential care strive to incorporate best practices, which can require significant changes to their procedures and organizational culture.

In California, legislation has been introduced (CA AB 1453, 2007–2008) to promote (1) short-term intensive treatment; (2) the offering of parallel, community-based services to help parents or other primary caregivers to maintain or develop a connection with the child and prepare for the child's return; (3) aftercare services to support the stability of the child and family following reunification or transition to family-based care; (4) improvements in

the service delivery decision-making pathway; and (5) better integration of the residentially based services within a county's continuum of care. These changes are designed to facilitate the ongoing movement of children and youth with complex emotional and behavioral needs toward more permanent and positive connection with their families, schools, and communities.

These national and state trends existed as the backdrop against which a 20-bed residential treatment facility in California examined its service-delivery model and embarked on a significant organizational change effort to improve post-discharge outcomes for its clients. This article describes the underlying philosophical, cultural, and programmatic changes that took place, as well as initial outcomes, one year later.

## THE ORGANIZATIONAL SETTING—SENECA CENTER

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

Seneca Center was founded in 1985 to provide "unconditional care" (Sprinson & Berrick, 2010) for young people and their families with exceptional emotional and behavioral needs, in response to the founder's observation that too many children and youth were bounced between placements, often discharged for exhibiting the very same behaviors that initially brought them into care. In 2001, Seneca established the "Oak Grove Community Treatment Facility" in Contra Costa County, CA, a residential treatment facility licensed by the California Department of Social Services and the California Department of Mental Health. The program was designed to serve adolescents ages 13–18, who would likely otherwise require long-term psychiatric hospitalization or long-term stays in out-of-state locked facilities. These clients generally had a long history of multiple placement failures prior to being referred to the Oak Grove program, usually for exhibiting high risk behaviors such as running away or injuring themselves or others. Oak Grove operated as a secure (locked) facility, providing assessment, service planning, therapeutic milieu services, individual, family, and group therapy, an onsite nonpublic school, intensive day treatment services, 24-hour psychiatric coverage, nursing services, and aftercare planning. The clients were "multi-stressed," often having encountered multiple traumatic life experiences, including sexual or physical abuse, separation from their families through foster care, multiple hospitalizations, substance abuse, as well as serious mental health issues. Almost all clients had prior experiences with more than one public agency, such as Mental Health Services, Social Services, or Juvenile Probation. Many were diagnosed with multiple DSM-IV disorders ranging from serious mood disorders (major depression, bipolar), to psychotic disorders, and behavioral disorders (oppositional defiant disorder). Most had also been prescribed multiple psychotropic medications.

Oak Grove provided a safe, stable placement with opportunities for adolescents to improve their lives by making changes in their destructive behaviors. However, the staff and leadership at Seneca Center recognized

that more needed to be done to help clients succeed after discharge, despite their best intentions and the good work being accomplished. While many of the clients were able to make significant changes within the safe confines of the residential program, many of them had a very difficult time "generalizing" these behavioral gains once they left residential care and soon relapsed back into their dangerous behaviors after transitioning from the program.

At the same time that the program staff members were contemplating program changes, Contra Costa County officials were exploring ways to best serve its high-need youth. A request for proposals was issued that called for a less-restrictive facility with a more robust "back-end" support system of step-down programs and aftercare supports, that was to be closely integrated with parallel Wraparound services, and focused on serving young people and their families through (1) shorter lengths of stay; (2) fostering connections between the youth and their primary caregivers, extended family, and community; (3) improving living and vocational skills; and (4) working to address specific behavioral challenges that would prevent a return to the community. Seneca Center worked with community partners to successfully bid a new continuum of programs that would include a redesigned Oak Grove program as the central hub. Over the next seven months, the leadership and staff at the Oak Grove CTF "overhauled" their program, and in February of 2008 opened the doors of the redesigned Oak Grove Center for Family Connections, an unlocked residential program with integrated Wraparound-funded community-based services for every child. In this way, Seneca and the county worked collaboratively to overhaul and redesign the program along the principles of System of Care and Wraparound philosophy, focusing on residential care as a treatment intervention that is part of a larger plan for the family and child.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

## Philosophical Changes

In redesigning the Oak Grove program, residentially-based services were explicitly reframed as "interventions" that must be integrated within a wide array of family and community-based services focused on enabling young people to achieve safety, well-being, and permanence in nurturing, family-like settings. This required a major shift in the way program staff would think about their roles, the organizational culture, and their stance toward clients and their families. Discussion over the course of seven months resulted in several philosophical shifts that would drive the new program's design. Underlying all of these shifts was the idea that unmet needs drive behavior and that the greatest unmet need is loneliness.

### We are a service, not a placement

In redefining the role of residential care, residential services were re-cast not as a "placement" in the traditional sense, but as short-term interventions,

services, experiences, and transformations contained within a larger process of help and support. While the program would continue to provide a safe, nurturing, and positive residential environment, the aim would not be to become a *home* for a child but to be a *service option* for a family, where key needs could be met for both the child and the family so that the child could be reintegrated into their family and community as quickly as possible. Part of the program's aim would be to foster the same sense of urgency as if the child were placed in the hospital for emergency care. The program, under no circumstances was to be used to "warehouse" children because public agencies "didn't know what to do with them" or simply for the sake of keeping them safe. In fact, creating a substitute homelike environment could contribute to the isolation of clients from their families and communities.

### We are not the family (limits of unconditional care)

A key philosophical shift in the new program involved recognizing, at the level of practice, that "we are not the family." This was a move away from the notion that troubled children need to be "saved" from their environments and "raised" by paid professionals. While one of the original program's greatest strengths was the ability to work with children with the most severe and complex needs, and to "hold onto" these children no matter what, the new program would have to acknowledge that care *is* conditional on the child's enrollment in the program. It would be important to remember that when clients leave (and staff members move on to the next phase of their careers), their relationships with the staff, no matter how meaningful, are not permanent connections.

### Every child has a family

Many children arrive at such a restricted level of care after multiple placements, and as a result are often systematically disconnected from their families. An underlying assumption is that the clients either "have no family," or that there are no "safe" family members. Exposure to Family Finding (Campbell, n.d.) led to the emphasis on the fact that *every* child does have many family members and that if the proper efforts are made to find and engage enough of them that, these families will step forward to contribute to the child's support. The program would be committed to developing permanent connections (family or family-like persons who will love a child for their entire lifetime) for every child that entered the program. For some youth, this would include the possibility of a permanent placement while, for others, it would result in a richer sense of family history and belonging, an exchange of letters, communication by phone, visits, or a destination for the holidays. Safety would still be the foremost concern that would drive interventions for all of the youth in the program, and it would be emphasized that increasing family connection would not be about reconnecting young people to

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

dangerous adults. Instead, it would recognize that family networks extend well beyond those caretakers from whom children in the system were initially removed, and that these often untapped networks often contain a wealth of resources and capacities.

### We serve families, not youth

The residential program had been focused on working with youth. If families were part of the treatment, they were generally seen as peripheral, and in many cases, as obstacles to the children's success. It is easy (and in many ways understandable) for staff working with youth with difficult behaviors that resulted from early-life trauma to carry conscious or unconscious "grudges" against the families of these children. While this bias usually comes from a place of care and concern for the children in the program, its long-term effect can be to keep children in residential care for long periods of time and further isolate them from their communities. The redesigned Oak Grove program would explicitly try to avoid this bias by consistently defining its clients as "families" rather than "youth." Staff would be trained and supervised to think about and work with the entire family system. This would require literally "opening the doors" to family, welcoming them in and making them the focus of the day-to-day operations.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

### Our help must be continuous and flexible

The new program is based on the idea that the services provided by the staff must be based on the unique needs of each youth and their family and that the program must be flexible enough to accommodate a variety of such needs. In the redesigned program, staff would work collaboratively with children and families to determine *individualized* treatment plans and goals based on their particular needs and values. This would require genuine compassion, respect, and curiosity about families, with input from the client and family built into the systems and procedures in a meaningful way. This would mean maintaining significantly more information about each client, what their goals for themselves were, and how the staff should work with them during day-to-day activities and respond to them during emergencies. Furthermore, staff would have the capacity to work with clients flexibly as they progressed through treatment, and even beyond, as they transitioned back into their communities.

### A broadened milieu

In traditional residential care, the heart of the treatment or help is delivered in what is commonly known as "the milieu." The previous Oak Grove

milieu had been highly structured and similar for all clients. In important ways, the previous milieu program had recognized youth as being successful in the milieu program when they could successfully adapt to its rigid (and somewhat artificial) structure. A youth's measure of progress was often considered as simple as their progress on the milieu-based "level system." In the new program, the milieu concept would be intentionally redefined and broadened. Rather than attempting to get kids to "fit into our milieu," the new program would be designed around the idea that it is our job to "determine what milieu we need to create for each child." This meant that the milieu would stretch far beyond the confines of the facility and into the greater community. It would recognize that every youth in the program would be coming from, and would ultimately return to, a different environment. The program's job would be to learn about each families "milieu" and partner with the youth and family in preparing themselves to make it a safe, healthy, and permanent place to live. This would, obviously, require staff to place much greater emphasis on spending time with clients and families outside the residential setting.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

### The stance we take matters

In order to effectively engage with and include families in the work, it would be essential that the program staff interact with them in a truly collaborative and respectful manner. This "stance" would need to go far beyond a mission statement of being "parent-driven" and would need to be defined by the very practices used in talking to families and in involving them in the service-planning and delivery. Rather than the program positioning itself as an "expert" on the youth and the families' problems, the engagement and service-delivery practices would be built around a genuine respect for the fact that youth and families have the most valuable expertise on their own problems. The program practices would be grounded in a curiosity about this fact and would be geared towards helping youth and families describe and define their problems from their own perspective. In this sense, the staff would be trained in becoming "appreciative allies" of the families (Madsen, 1999).

The major philosophical shifts are summarized in Table 1.

### Creating organizational change

In order to prepare the program staff for the rather dramatic changes that would be coming, the program leadership took several measures to help ensure that the culture and organizational change would be effective. There were open discussions with all levels of staff regarding the underlying factors driving the program changes. These discussions included reviews of the poor national outcomes for youth exiting residential care as well as the

**TABLE 1** Program Philosophy Before and After Oak Grove Transformation

| Old program philosophy | New program philosophy |
|---|---|
| Youth in residential care don't have families | Every child has a family |
| We are the child's family | We are not permanent connections—our job is to find permanent connections for every child |
| Youth are our clients | Families are our clients |
| We are a placement | Our residential program is a service aimed at preparing a child and family to move back into the community |
| We are the experts on our client's problems | The youth and family are the experts on their own problems |
| Residential care is the goal | Residential care is an emergency |
| Youth need to adapt to our milieu | We need to learn about the milieu our youth will be returning to |
| A culture of safety | A culture of tolerated risk |

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

historical data for youth that had graduated the Oak Grove program. During these discussions, many staff spoke to the fact that they could personally identify too many former clients who, upon discharge, were not well connected to permanent, dependable adults, or struggled to adjust to "non-institutionalized" life. In short, these discussions helped clarify the program staff's desires to better serve and prepare the youth they worked with to succeed when they left care. The following story is an example of one used to help emphasize this change imperative (Schein, 2004) to staff:

> The recognition of a need for change was clear at the funeral for a young girl who we had worked with intensively for a year and a half . . . During her time with us we had successfully built meaningful relationships with her and had helped her valiantly resurface from a debilitating depression. We had helped her find the courage, for the first time in her life, to make plans for herself—including college and a career—and had helped her actually believe that she could make them happen. In spite of this success, however, something was still missing. Several months after leaving the program she succumbed, again, to her depression and took her own life. As painful as this news was for those of us who loved her, the real blow came at the funeral when it became incredibly clear what it was that we had missed: there, in the pews of the small funeral home, were rows and rows of family members that we had never met. (Oak Grove Program Design Narrative pg. 4)

The re-designed Oak Grove program was described to staff in the following way:

> To provide outstanding and unconditional care with the goal of improving families' lives, we will work collaboratively with them . . . We will hold

hope even in seemingly hopeless situations, recognize the incredible courage it requires to persevere through the challenges our families face, courageously commit to working with families "no matter what," and share in the joy that healing and reconnecting brings. The help we provide will be given in the spirit of "we" and never "us and them" . . . Our practices and interventions will be driven by the systemic recognition that children do not exist or thrive in isolation.

## The Re-Designed Program, Key Features and Components

The service-planning and delivery process at the new Oak Grove Center for Family Connections is called the Collaborative Family Connection Process (CFCP). This process mirrors closely the Wraparound service-planning and delivery model and is centered on the development of a Child and Family Team that drives all planning and service-delivery. The major addition to the traditional Wraparound model is the explicit focus on the Family Finding step of Discovery for those youth with minimal or no known family members at intake. This integration of Wraparound and Family Finding principles and practices across multiple service-delivery settings (residentially based and community-based) is what allows the philosophical shifts noted above to become a part of actual day-to-day practices.

The basic phases of the Collaborative Family Connection Process are described in Figures 1 and 2 as follows:

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

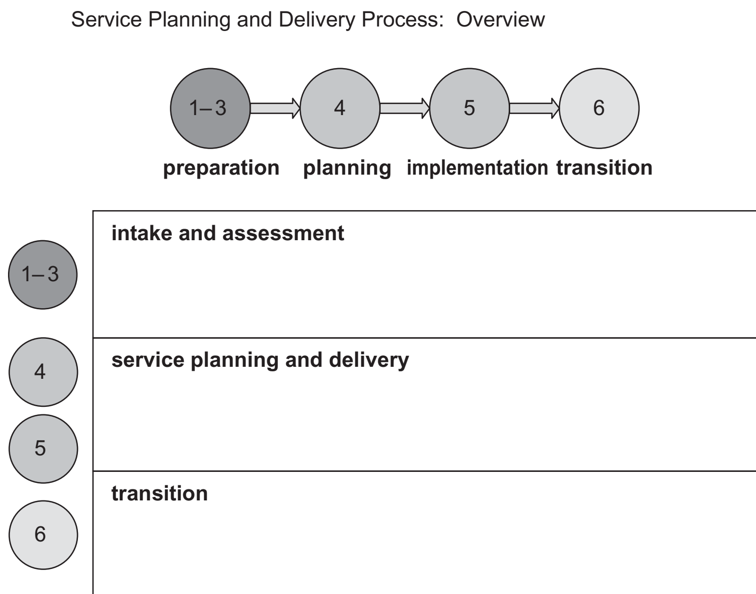



**FIGURE 1** The basic phases in the Collaborative Family Connection Process.

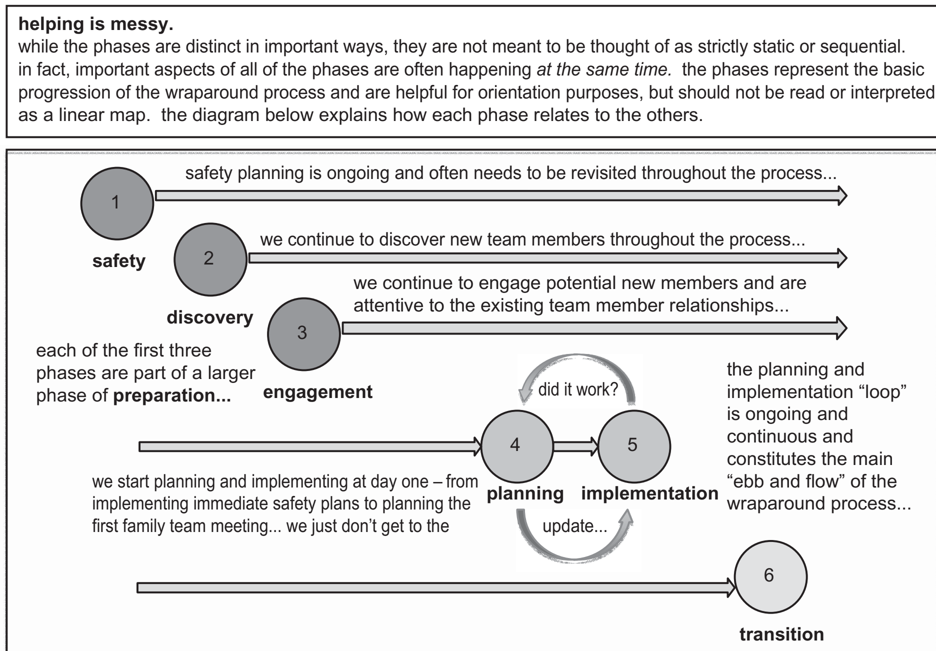



**FIGURE 2** A description of the "ebb and flow" of phases in the Collaborative Family Connection Process.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

## Key Program Features

### Family finding

After establishing a safety plan, program staff members begin the process of discovering, engaging, and empowering adults who have been or can be key supporters of the child or parents to become key parts of the planning and service delivery process for the youth in care. Strategies for finding these adults include interviewing family members and others who know the family well, mining files, using Internet search technology, making phone calls, writing letters, and neighborhood outreach, using the "Family Finding" techniques as taught by Kevin Campbell. The goal is to identify a minimum of 40 permanent connections for each youth, at least four of whom can be significantly involved in the client's service planning, and who will be committed to their well-being and safety after transitioning out of formal services.

### Family teams

The central driving force behind every child's service planning is what is known as the Child and Family Team (CFT) or Collaborative Family

Connection Team (CFCT). The primary goal of the first three phases of the Collaborative Family Connection process is the creation of this team. Each client's team is made up of key supportive adults identified in the discovery and engagement phases of the CFC process, Seneca program staff, and important outside professionals. Seneca program staff can include a care coordinator, a team manager, a therapist, psychiatrist, residential counselor(s), school counselors, and community-based counselors. Each child and family has approximately 6–10 Seneca staff assigned to their CFC team. Important outside professionals—placing agency workers, lawyers, CASA workers, outside therapists—are also included on the team and often play a key role in decision-making. The most important members of the team are the "informal" or "permanent" members of the team. These members can be the youth's parents, extended family, or any other community members committed to the youth's safety, permanence, and well-being. This team is at the center of the Collaborative Family Connection process for every family in the program and works together to devise and implement plans that are uniquely individualized, that build on the strengths and values of the family, and that address and meet the key needs of the family as they arise. This same core team works with the youth from the time they enter the residential program until they transition out of formal services.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

### Family team meetings

The CFC teams meet on a regular basis in what is called a Child and Family Team meeting or Collaborative Family Connection Team meeting. These meetings occur weekly and last approximately one hour, held at the facility or in the family's home. The meetings follow a scripted process that is geared towards helping the team stayed focused on "the things that matter most." The most pressing, and underlying "needs" of the child and family are identified and the team stays focused on addressing the most important of these with the express goal of meeting them "well enough" so that the child can safely leave residential care and return to the community. The CFC Care Coordinator runs these meetings at the beginning of the process with the ultimate goal of transitioning this job to the informal members of the team. The meetings focus on completing the phases of the Collaborative Family Connection Process. Discharge plans are revisited, strengths, needs and values/goals are revisited, and action items are generated for follow up. Staff dress and demeanor connote respect towards the family, and while the facilitator determines the meeting structure, the client and family significantly determine the content.

### Concurrent discharge planning (saying goodbye at hello)

It is imperative that the CFC team be engaged in identifying, specifically, what stands in the way of a child leaving residential care (what behaviors

need to change and by how much; what community supports need to be identified and strengthened and by how much) so that the entire team understands the goal and is working with a sense of urgency. One of the most dangerous obstacles to using residential care effectively is the traditional and collective "sigh of relief" that often coincides with "placement." This reaction results in an unspoken, and often unconscious, desire to keep kids in residential care longer than necessary because it is "easier" for the adults charged with taking care of them. Establishing and reviewing, in every meeting, transitional goals and timelines helps to counter this tendency. Establishing concurrent discharge plans is also a key feature of the CFC process. Each CFC team identifies and works concurrently toward a primary discharge plan and three alternative plans at all times. While this can be a difficult process at times and can create some tension in the planning process (who is Plan A and why; who is Plan B), it helps ensure that the necessary planning and support is in place should the teams original plans fall through for any reason. These plans are revisited and updated in every CFC Team meeting and team members are assigned concrete "action items" to help ensure that this planning is moving forward.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

### Client-centered staff structuring

In order to maintain complex individualized plans for clients, staff teams are organized with counselors from each of the program's main areas: residential counselors, awake overnight counselors, school counselors, and community-based counselors. Teams are assigned to a subset of the families so that every counselor-level staff is assigned to only 3–4 clients and families. Moreover, staff schedules ensure that, at any given time, there will be a team member present on staff who will be familiar with the treatment plan for each client, to act as an "appreciative ally," with knowledge of the clients' individualized plan. Staff are trained on multiple job functions (both residentially-based and community-based), so that the same team members can stay with a client and family from intake, through residentially and community-based services, and transition from formal services. This allows the child and family to avoid the traditional "hand-off" (see Figure 3) between professionals that often slows their progress down as they are required to "start from scratch" every time a new provider needs to "assess" them again (perhaps for the 15th time) before beginning to help them. For this to be successful, staff schedules are adjusted so that all staff have "flex time" built into their schedules. This is time in which they are not committed to working in the residential program but are responsible for completing whatever "action steps"; they are assigned in the CFC team meetings that will help meet the needs identified by the CFC team. These action steps may include conducting Family Finding tasks, working with identified family members

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

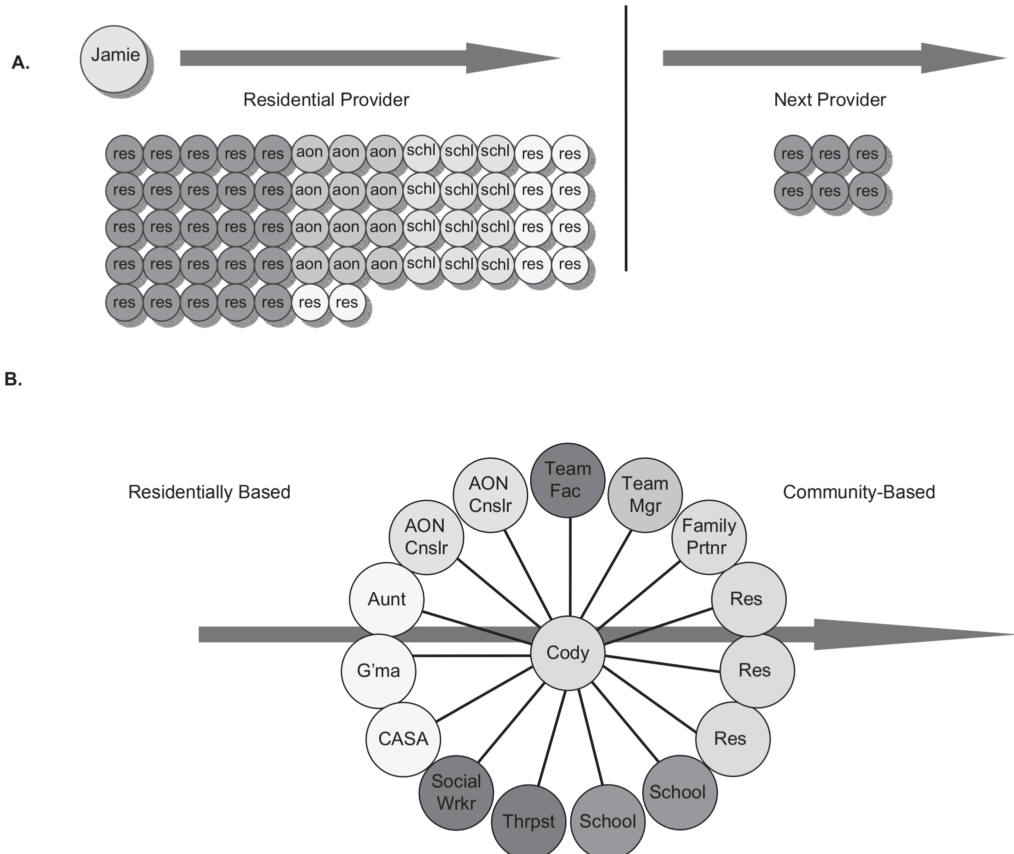



**FIGURE 3** To Avoid the "hand off" (A), the same Child and Family Team drives the service planning and delivery in both the residentially based setting and the eventual community-based Setting (B).

on preparing for the youth to live in or visit their home, working with the youth on getting a job, or helping him or her to find healthy hobbies.

### Circle[1]

A central component of the Oak Grove program that was not changed during the redesign is what is known as "Circle." Circle is a non-traditional form of group therapy that invites and requires all members of the Oak Grove community—staff and youth alike—to live according to agreed upon community guidelines and to hold each other accountable to learning and living by these guidelines. Circle is the fabric of the Oak Grove community and creates a model for the youth, staff, and families to learn what it means to be a part of a community and what it takes to live within a community in a healthy and safe manner. Circle is designed to create a safe, communal environment in which youth can explore, practice, and ultimately master the relational skills they will need to succeed in their lives. All youth and staff members are expected to attend and actively participate. Circle occurs four afternoons a week and lasts between 1 1/2 and 2 1/2 hours. The content of Circle varies but revolves around central themes: improving relationships, building individual skills (from communication and social skills to emotion regulation and mindfulness skills), celebrating accomplishments, taking responsibility for behaviors, strengthening community connections, resolving conflicts, and developing community plans. The format is ritualized and the process is built on an agreed upon set of community guidelines to ensure respect and allow openness.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

### Professional development

In order for Circle to function in an effective manner within the Oak Grove community, it is important that all the staff working in the program are committed to learning, practicing, and living by the Community Guidelines. To facilitate this process, all levels of staff participate weekly in a parallel group process called "Professional Development." The format of Professional Development is also ritualized and mirrors the process of Circle in many ways. Staff are invited to "sharpen their own saws" with regards to the relational skills, mindfulness skills, emotion regulation skills, and responsibility-taking skills that are taught in Circle. Staff are held to the maxim that "you shouldn't ask someone to do something you aren't willing to do yourself." The process of Professional Development also provides a forum for staff to work through the often intense emotional reactions they might have with respect to the difficult behaviors the youth and their families sometimes display. It also provides an opportunity for staff members to have access to program leadership in a reliable manner. Staff members are encouraged to bring concerns and questions directly to supervisors "in their relationships." This

built-in staff process became an important method for staff to voice their concerns regarding the proposed changes and have the opportunity to be heard by leadership. Such communicative practices would be invaluable in fostering readiness for and eventual success of implementation.

### Therapeutic behavioral services

Another important part of the Oak Grove program re-design was the inclusion of "integrated" Therapeutic Behavioral Services (TBS) workers in the program. These staff are specifically and specially trained in assisting youth and their families to design and implement behavioral plans for their most problematic behaviors. TBS staff members are assigned to CFC teams through a referral process when the team decides that such an intense focus on a particular behavior would be helpful. This evidence-based intervention generally targets specific assaultive or self-injurious behaviors which might otherwise prevent a youth from returning to the community.

Table 2 summarizes the key programmatic changes at Oak Grove.

### Cost

The program model described is funded through several streams and requires County partners that are willing to be innovative and creative in funding a unique program model. An important note here is that this model is only functional in situations where providers are able to access a funding stream for both community-based and residentially-based services. While some aspects of the program will still be applicable without this, the entirety of the program model is clearly dependent on this set-up. As mentioned previously, there are significant costs associated with creating the capacity to provide the integrated Family Finding and Wraparound (Collaborative Family Connection Process) services for every youth in the residential program. While these initial costs are significantly

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

**TABLE 2** Program Implementation Before and After Oak Grove Transformation

| Oak Grove prior to transformation | Oak Grove after transformation |
|---|---|
| "One Size fits All" milieu structure | Individualized and broadened milieu concept |
| Locked residential program | Unlocked residential program |
| Service plans were created by clinicians who did not interface with youth regularly | Staff who participated in service planning are available to youth at all times |
| Focus on stabilization | Focus on transition starting at intake |
| Long lengths of stay | Goal of shorter lengths of stay |
| Primary focus of work is in the residential setting | Primary focus of work is in the community where the youth will be returning |
| Any after-care services were done in a "hand-off" manner | All services, from intake to transition from formal care, are provided by the same staff |

higher than those for traditional residential services, the long-term savings are significant if the services are successful in moving youth out of residential care and into community-based settings quickly, effectively, and permanently.

## EARLY OUTCOMES

To evaluate the program transformation, staff were interviewed and clients' electronic records were retrospectively analyzed.

### Staff Reaction

Two months after the opening of the redesigned program, a sample consisting of seven staff members was interviewed about the program redesign and asked several open ended and numeric questions. When asked to rate the magnitude of change they experienced in the program (on a scale of 1 "Not much change at all, I heard about it but didn't see much difference in the day-to-day" to 7 "A huge change"), the response was very strong, with a mean response of 6.5. When asked whether they felt good about the change (on a scale from 1 "Terrible" to 7 "Wonderful") staff again responded strongly that they felt good about the change (M = 6.5). Staff also indicated they felt very engaged in their work, with a mean response of 6.17 on a scale from 1 "Not at all" to 7 "I feel I am able to do incredibly meaningful work."

Following are some narrative comments made by staff members about the program change:

> Getting to know their families has made a huge difference . . . I see them interacting and I feel really good, these people love each other.
>
> You may have made judgments before . . . then you meet them and, they're here they're at these meetings, and they're working things out themselves . . . less judgment after I meet them.
>
> With the doors being unlocked, that creates a culture for the kids of "we want you to be here, we want that to be your decision."
>
> I felt like I was able to have input . . . we're the ones who are on the floor with them . . . 40 hours a week so, just being able to bring that knowledge and give input, for everyone, made me feel like I had more of an impact.
>
> I guess I could say [my job is] "harder" in the sense that you have to be prepared and you've really got to know what's going on. But that in itself kind of makes it easier also, just because you do feel more prepared, you feel like, you begin to trust yourself more.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

## Staff Turnover

Staff turnover at Oak Grove has always been relatively high, often due to the fact that many staff leave their jobs to continue their training and education. Figure 4 shows the number of employees terminating employment (for any reason) for each month of the two years prior to the program redesign and during the first year of the newly designed program. Despite the significant changes that took place, the program transition did not result in increased staff turnover.

## Client Outcomes

### Length of stay

One program objective is to reduce client lengths of stay in residential care. Review of enrollment records revealed that sixty-four clients were enrolled at Oak Grove during its CTF phase, with an average length of stay of 16.58 months (SE = 1.582, min = .03 months, max = 55.43 months). Fifteen clients were enrolled in the redesigned program, with a mean enrollment duration of 9.14 months (SE = 1.038, min = 3.10 months, max = 17.40 months), see Figure 5. (Twenty-seven additional clients had multiple enrollments, spanning either one or both program incarnations.)

### Family involvement

Using Internet and offline searching, an average of 26 family members was identified per client. A total of 561 "Family Team Meetings" were conducted, with 92 different family members attending (typically 2–5 family members

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

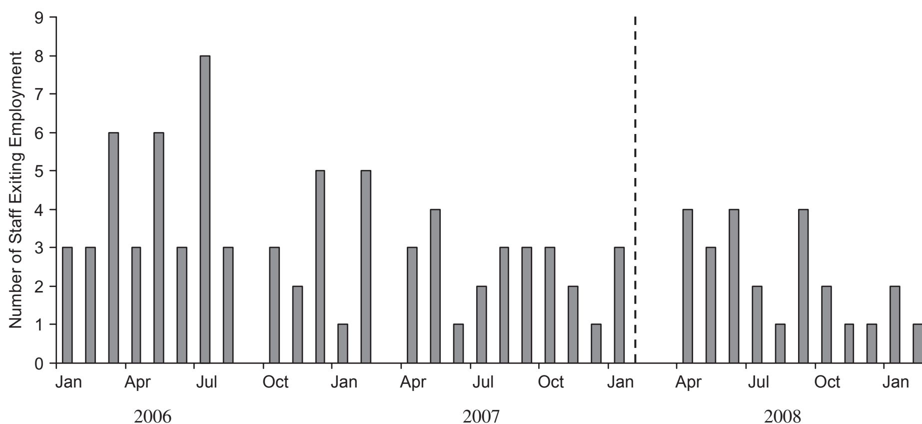



**FIGURE 4** Number of staff who terminated employment for each month, two years before and one year after the program redesign. The dotted line indicates the program transition date.

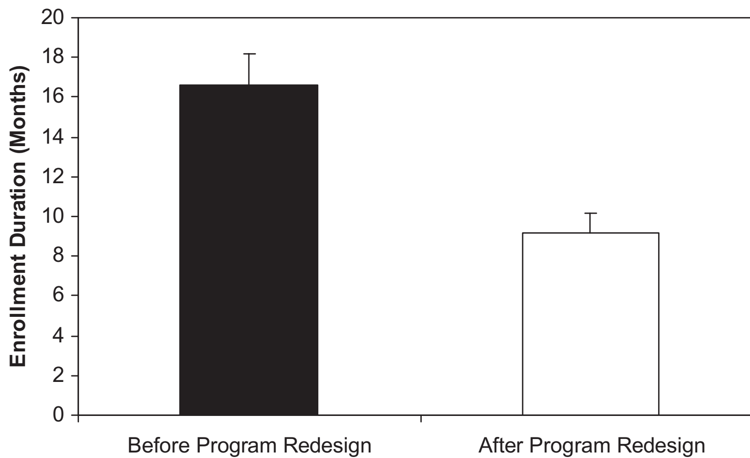



**FIGURE 5** Mean client enrollment duration before and after the program redesign. $N = 64$ pre-redesign. $N = 15$ post-redesign.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

per youth). At least one family member (or "family like" member) was present at 87% of the family team meetings.

### Daily points

Each day, clients work toward specific, individualized behavioral goals, such as "Samantha will engage a peer in positive conversation." Clients are awarded points each day on their success with each goal. Staff members write and update goals so they are always challenging, so a client should not consistently score very low nor should they score full points consistently either. Figure 6 shows the mean number of points scored by clients each

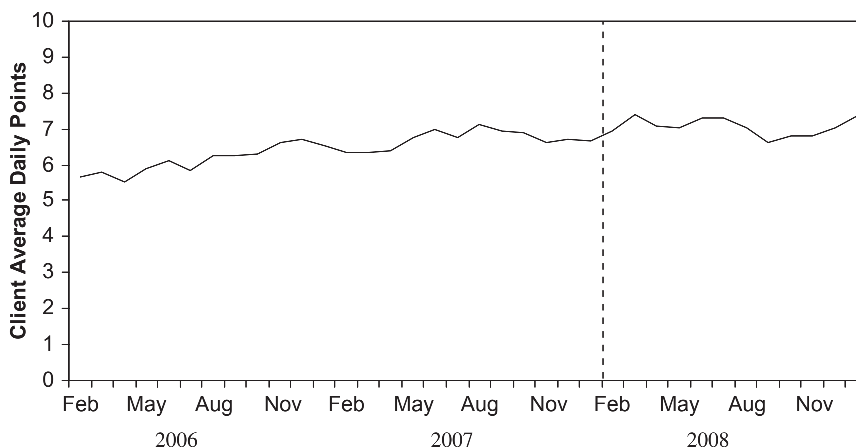



**FIGURE 6** Mean number of points scored by clients toward their daily goals before and after the program redesign.

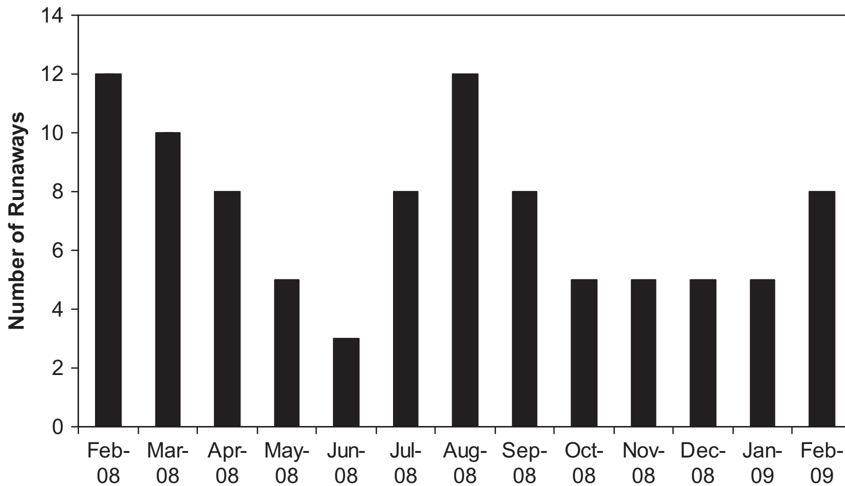



**FIGURE 7** Number of client runaways per month since the program redesign.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

month during the two years prior and 1 year after the program redesign, showing that the program redesign did not cause destabilization of the milieu.

### Runaways

Figure 7 shows the number of clients who "walked away" from the program during each month of the first year of the transition program. It is important to note that these incidents did not result in the client being discharged from the residential program. Each time, the client returned to the program to continue their enrollment.

### Discharges

One year after the program transitioned, 20 clients had been discharged from the redesigned program. Fifteen of these clients "stepped down" to a lower level of care, and five clients "stepped up," see Figure 8.

## DISCUSSION

As residential programs look to ways to implement similar changes, this case study offers encouragement that meaningful change can be made, with most clients persisting successfully through the program transformation. Both staff perception and initial program data indicate that the program change was accomplished. Staff were able to adapt to changing job demands without an increase in turnover, and family members were able to be located and did participate in treatment planning. Runaways did persist, but

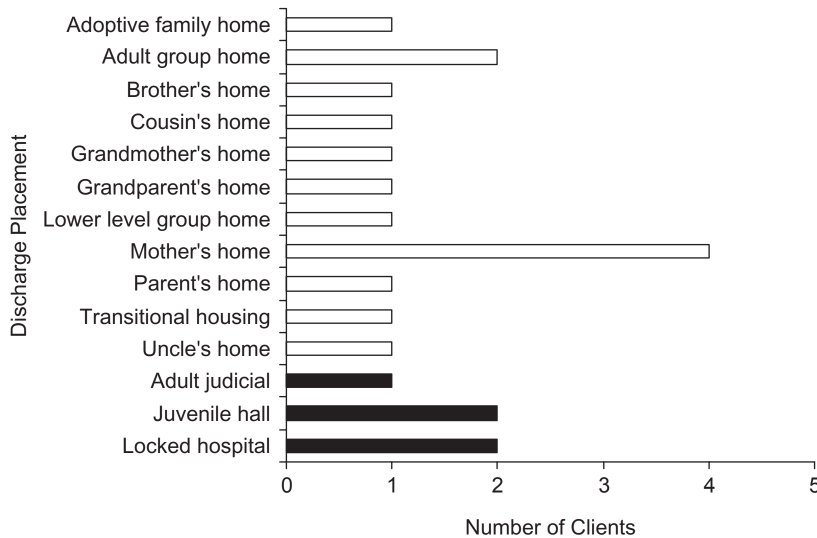



**FIGURE 8** Discharge placement type for client's who discharged the redesigned program during the first year.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

overall program structure was generally maintained and most clients were successfully discharged to a lower level of care. The short term indicators of success such as length of stay and involvement of family are very promising; however, the long term program outcomes and ultimate impacts on participating youth are still unknown. There seem to be several factors that contributed to the ability of the Oak Grove program to accomplish meaningful organizational change: (1) staff held a shared belief that a change was needed; (2) leadership demonstrated their commitment to change by committing time to developing a group process that emphasized listening; and (3) key beliefs and goals were examined and reframed which helped to create a shift in culture. The degree to which external conditions at the national, state, and county levels were a positive factor in fostering change is not known but assumed to have added value. Of great value were the cultural and communication norms of the organization, which held a deep respect for active listening and raising to consciousness all conflicts. These helped create an open process where fears of change were intentionally and successfully addressed. Future research will explore longer term outcomes for youth and families in this new program model.

## NOTE

1. The Circle group therapy described here is based on the practice used at "Family Life Center" in Petaluma, CA. It was originally developed by Larry M. Simmons for use at "PREHAB" in Mesa, AZ (now called "A New Leaf"). Circle was modified for use at Seneca by Mike Mertz and Daren Dickson.

## REFERENCES

*All county information notice I-06_08: Request for letter of intent from counties to participate in California's group home reform effort*. (2008, February 7). Retrieved February 17th, 2010, from http://www.rbsreform.org/materials/I-06_08.pdf

Bazelon, J. D. L. (2009). *Fact sheet: Children in residential treatment centers*. Retrieved from http://www.bazelon.org/issues/children/factsheets/rtcs.htm

Bettmann, J. E., & Jasperson, R. A. (2009). Adolescents in Residential and Inpatient Treatment: A Review of the Outcome Literature. *Child & Youth Care Forum*, *38*(4), 161–183.

California Alliance of Child and Family Services. (2006). *Framework for a new system of residentially based services*. Retrieved February 17th, 2010, from http://www.rbsreform.org/materials/RBS_Framework.doc

California Assembly Bill (CA AB) 1453. (2007–2008 session). Retrieved from http://www.leginfo.ca.gov/pub/07-08/bill/asm/ab_1451-1500/ab_1453_bill_20071011_chaptered.pdf

Campbell, K. (n.d.). *Six steps for family finding*. Retrieved February 17, 2010, from http://www.senecacenter.org/files/familyfinding/Six%20Steps%20for%20Family%20Finding.pdf

Castillo, E., & Davis, L. (2007). Transforming a youth residential program with positive behavior supports, families, and communities. *NADD Bulletin*, *10*(1), 3–10. Retrieved from http://www.emqff.org/press/docs/NADD_Bulletin_Volume_X_Number_1_Article_2.pdf

Commission on California State Government Organization and Economy (2003). *Still in our hands: A review of efforts to reform foster care in California*. Retrieved from http://www.lhc.ca.gov/studies/168/report168.pdf

Frensch, K. M., & Cameron, G. (2002). Treatment of choice or a last resort? A review of residential mental health placements for children and youth. *Child and Youth Care Forum*, *31*(5), 307–339.

Friedman, R., Pinto, A., Behar, L., Bush, N., Chirolla, A., Epstein, M., et al. (2006). Unlicensed residential programs: The next challenge in protecting youth. *American Journal of Orthopsychiatry*, *76*, 295–303.

Hair, H. J. (2005). Outcomes for children and adolescents after residential treatment: A review of research from 1993 to 2003. *Journal of Child & Family Studies*, *14*(4), 551–575

Knitzer, J. (1982). *Unclaimed children: The failure of public responsibility to children and adolescents in need of mental health services*. Washington, DC: Children's Defense Fund.

Madsen, W. C. (1999). *Collaborative therapy with multi-stressed families*. New York, NY: Guilford Press.

Miles, P. (2007). *Meeting needs: Increasing the precision intervention* [PowerPoint slide]. Retrieved February 12, 2010 from http://paperboat.com/images/stories/Presentations/Pat_Miles_Presentations/needssenecajune2007.swf

New Freedom Commission on Mental Health (2003). *Achieving the promise: Transforming mental health care in America. Final Report*. Rockville, MD: Department of Human Services.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010

Pumariega, A. J. (2007). Residential treatment for youth: Time for reconsideration and reform. *American Journal of Orthopsychiatry*, *77*, 343–345.

Rosenblatt, A., & Woodbridge, M. W. (2003). Deconstructing research on systems of care for youth with EBD: Frameworks for policy research. *Journal of Emotional and Behavioral Disorders*, *11*, 27–3.

Schein, E. H. (2004). *Organizational culture and leadership*. San Francisco, CA: Jossey-Bass.

Sprinson, J. S., & Berrick, K. (2010). *Unconditional care: A guide for working with vulnerable children and families*. New York, NY: Oxford Press.

Stroul, B. A., & Friedman, R. M. (1994). *A system of care for children and youth with severe emotional disturbances*. Washington, DC: Georgetown University, Child and Adolescent Service System Program (CASSP) Technical Assistance Center.

Stuck, E. N., Small, R. W., & Ainsworth, F. (2000). Questioning the continuum of care: Towards a reconceptualization of child welfare services. *Residential Treatment for Children and Youth*, *17*(3), 79–92.

Downloaded By: [Chance, Sarah] At: 21:10 30 April 2010