Moving Forward: Building Bridges Towards Systems Transformation and Making Trauma-Informed Care Real

Dr. Janice LeBel
Rhode Island College ~ Sherlock Center on Disabilities
March 9, 2015
Outline

• Overview of the National Building Bridges Initiative (BBI)
• How BBI intersects with restraint & seclusion use and trauma-informed care
• The MA Initiative to transform treatment & residential services
Grateful Acknowledgement
to Beth Caldwell
National Director of the
Building Bridges Initiative

Overview and Highlights of the Building Bridges Initiative

Beth Caldwell: Director, Building Bridges Initiative (BBI)
National Building Bridges Initiative
BBI Mission

Identify and promote practice and policy initiatives that will create strong and closely coordinated **partnerships and collaborations** between families, youth, community- and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive services and supports are **family-driven**, **youth-guided**, **strength-based**, **culturally and linguistically competent**, **individualized**, **evidence and practice-informed**, and **consistent with the research on sustained positive outcomes**.
Highlights

• Began in November 2005
• National Steering Committee formed
• Joint Resolution developed at 2006 Summit
  △ Identifies Core Principles
BBI Core Principles

- Family Driven & Youth Guided Care
- Cultural & Linguistic Competence
- Clinical Excellence & Quality Standards
- Accessibility & Community Involvement
- Transition Planning & Services (between settings & from youth to adulthood)
BBI Highlights (cont.)

- **Workgroups:**
  - Outcomes
  - Youth/Family Partnerships
    - Family Advisory Network
    - Youth Advisory Group
  - Cultural & Linguistic Competence
  - Fiscal/Policy

- **Documents:**
  - Joint Resolution
  - Matrix/Self Assessment Tool
  - Family & Youth Tip Sheets
  - Child Welfare Fact Sheet

*Many now available in Spanish*
Highlights (cont.)

- National Publications:
  - National Council for Community Behavioral Healthcare
  - Teaching-Family Association
  - CWLA Special Edition on Residential
- State, County, City and Individual Program Initiatives
- Partnerships
  - Funding (Summits/Webinars)
  - Endorsing Joint Resolution
  - Promoting systems change
- Website: [www.buildingbridges4youth.org](http://www.buildingbridges4youth.org)
Some of the Critical Issues

- Research on residential effectiveness
  - Recidivism/Readmissions
    - 68% in one state (2009) for all licensed residential programs vs. Damar Services (BBI implementer) with ranges from 3-11%
  - Lengths of Stay
    - NYS (Average: 14 months in 12+ years) vs. FL (<6 months in 3 years)
Critical Elements for Better Outcomes

- Residential-specific research shows improved outcomes with: 1) **shorter lengths of stay**, 2) **increased family involvement**, and 3) **stability and support in the post-residential environment** (Walters & Petr, 2008).
The research in out-of-home care consistently shows that the processes and outcomes of care improve in correlation with the degree of family involvement.
Importance of Family-driven Care

• **Strongest predictor** of post-transition success, after **education**, is **support from family**; 50% of youth who have aged out will live with some member of their family within a couple of years, about equally divided between parents and other relatives;  

• “**Work with family issues and on facilitating community involvement while adolescents are in residential treatment**” may have assisted these adolescents to maintain gains for as much as a year after discharge..”  
  (Leichtman, M., et al, 2001)
And...

"the effectiveness of services, no matter what they are, may hinge less on the particular type of service than on how, when, and why families or caregivers are engaged in the delivery of care. While traditional forms of care approached mental health treatment in a hierarchical top down approach (with the clinician maintaining some distance from the recipients of treatment), this approach is not reflected in newer forms of service delivery. It is becoming increasingly clear that family engagement is a key component not only of participation in care, but also in the effective implementation of it" (p. 238).

(Burns, B. et al, 1999)
Whose job is it to ensure family involvement?

No matter who the family is or what challenges they are presenting?
IT IS OUR JOB – EACH AND EVERY ONE OF US
What does Family-driven Care Mean?

“Family-driven means families have a primary decision making role in the care of their own children .... This includes: choosing supports, services, and provider; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; ...”
Examples of where BBI/ residential best practices are happening?

- Comprehensive State initiatives (DE, IN, MA, CA – initially 4 regions)
- Initial State level activities (NH, AZ, LA, NM, ND, OK, WA)
- County/City level initiatives (City: NYC; Counties: Monroe/ Westchester, NY & Maricopa, AZ)
- Many individual residential and community programs across the country
Vision: LA County RBS Project

The creation of a strength-based, family-centered, needs-driven system of care that transform residential facilities from long-term placements to short-term family driven open therapeutic communities, which are not place-based and concurrently provide for seamless transitions to continuing community care, which support the safety, permanency and well-being of children and their families.
California Residential Project

- Studied research & outcomes w/support from AEC Foundation
- Transformed from long-term congregate care to short-term stabilization and treatment with follow along community-based services
- 2 key steps at referral: a) Family Search & Engage, b) develop network for support for y/f
- 2 key components: a) flexible supports/wraparound & b) family advocates
Additional RBS Resources

Information on the California RBS Reform Coalition project and other County models can be found at: www.rbsreform.org
Contact Information

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E-mail: williammartone@hathaway-sycamores.org
Our job is **not to cure kids** but rather to help kids and their families negotiate the basic tasks of everyday life.

“Residential treatment” should be oriented not so much around removing problems kids bring to care but toward **establishing conditions that allow children and families to manage symptoms and crises more effectively at home and in the community.**
Damar Services, Inc.

- Studied outcomes
- Changed business model
  - 2 year funding commitment & return policy
- Changed geography requirements
  - 50 miles
- Changed staffing model
  - Direct care staff are primaries
- Changed where service is delivered
  - Res treatment = youth/families residence
- Changed provider expectations thru partnerships
Indiana – Damar Services, Inc.

- Collection of recidivism data for 5 years post-discharge

<table>
<thead>
<tr>
<th>Year</th>
<th>Recidivism Rate</th>
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<tbody>
<tr>
<td>2005</td>
<td>4%</td>
</tr>
<tr>
<td>2006</td>
<td>11%</td>
</tr>
<tr>
<td>2007</td>
<td>9%</td>
</tr>
<tr>
<td>2008</td>
<td>3%</td>
</tr>
<tr>
<td>2009</td>
<td>8%</td>
</tr>
<tr>
<td>2010</td>
<td>6%</td>
</tr>
<tr>
<td>2011</td>
<td>7%</td>
</tr>
<tr>
<td>2012</td>
<td>8%</td>
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</tbody>
</table>

Recidivism typically within first 12 months after discharge
Definition of “Recidivism”

During the 5-years post “discharge” from the residential care setting, the youth is not placed in a similar or higher level of care.
Indiana – Damar Services, Inc.

- Critical Incident of Primary Concern
  If 24 hours goes by and a youth is not with his/her family and/or in his/her home community, it is considered a Critical Incident for the Agency and a plan of action/correction must be submitted to the COO*.  
  (Note: Phone calls do not count.)

*Internal Quality Plus Threshold is 95% for Agency.  If it’s not measured, it’s not managed.

- Take youth/family back for free if requires placement post-discharge (started as 1 year commitment now is 3 years)
Damar Contact Information

Dr. Jim Dalton, President and COO
Damar Services, Inc.
www.damar.org
(317) 856-5201
jimd@damar.org
New York – The Children’s Village

- CEO, COO and all VPs/Directors required to have open door policy to any family member
- Hired Parent Advocates (full-time, salaried and with benefits)
- Provide evidence-based parent education in English and Spanish
- Trained and launched Family Team Conferences (FTC)
  - Since some parents could not attend, developed mobile FTC Conference Centers
- Developed a variety of successful short-term (21-day, 28-day, 40-day, 100-day) residential models to provide stabilization and crisis respite for teens
- Beginning in 2005, secured “flex funds” for family support (available to all staff and Parent Advocates)
- Outcomes:
  - Overall median, annual length of stay for teens drop from over 24 months to under 6-months
  - Last year, over 800 teens were discharged in under 40-days
Outcomes for MST Intervention for 15% at “highest risk” (who previously consumed 75-85% of all aftercare/flex resources)

<table>
<thead>
<tr>
<th>Outcomes 2008 – 2010 6-month treatment</th>
<th>MST/WAY Treatment 25 youth and families</th>
<th>Comparison 23 youth and families</th>
</tr>
</thead>
<tbody>
<tr>
<td>In School</td>
<td>19 (76%)</td>
<td>10 (43%)</td>
</tr>
<tr>
<td>Arrests</td>
<td>4 (16%)</td>
<td>12 (52%)</td>
</tr>
<tr>
<td>Failure to remain at home</td>
<td>5 (20%)</td>
<td>16 (70%)</td>
</tr>
</tbody>
</table>

CV privately funded specialized MST teams to provide these families with the intensive support they needed.
Jeremy Kohomban, PhD
President and Chief Executive Officer
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jkhomban@childrensvillage.org
Specific Examples of Family-Driven, Youth-Guided Practices
Examples of Practices you would see:

- Every Staff is ‘Director of First Impressions’
- Families can come to program 24/7
- Warm and comfortable physical environments
- Families can go to every part of the program – spending time in their child’s room and classroom and activities
Examples of Practices you would see:

• Lose the words ‘home-visits’
• Family focus groups decide education offerings for families
• Families called everyday to share child strengths – not just about issues & encouraged to call multiple times daily
• Youth call different family members multiple times daily
• Ensure families have dedicated time to talk with front line staff
• Make it a practice to consult with families to seek counsel and engage in decision-making
Examples of Practices you would see:

- Create opportunities (i.e. weekend camping) for families to be proud of their children/to create positive memories
- Support siblings
- NO MORE GROUP REC – all recreation focused on youth individual interests/talents and any ‘group’ activity involves siblings/families/extended families- i.e. cousins
- Gather tickets/freebies for families to use with children (maybe with a staff for support)
- Develop close collaborations with clinical expertise in community (e.g., trauma; SA; DV) & supports (e.g., housing; community activities; peer mentors; respite)
What to be cautious of:

- Events on residential campuses (why?)
- Lack of sophisticated/committed Clinical Supervisors
- Group residential recreation (why?/who to invite? (build memories with families)
- Residential holiday traditions (“Is it about the program or about the youth/family?”)
BIG STEPS AND SMALL STEPS

- All count
- A number of family-driven & youth-guided practices have been identified that support better outcomes
A first step…

- Go to BBI website!  
  [www.buildingbridges4youth.org](http://www.buildingbridges4youth.org)

- Many important resources and articles to support the field – newer documents include:
  - BBI Fact Sheet on Child Welfare
  - Fiscal Strategies that Support the Building Bridges Initiative Principles
  - Cultural and Linguistic Competence Guidelines for Residential Programs
  - Handbook and Appendices for Hiring and Supporting Peer Youth Advocates
  - Engage Us: A Guide Written by Families for Residential Providers
  - Numerous documents translated into Spanish (e.g., SAT; Family and Youth Tip Sheets)
A second step...

- Endorse the BBI Joint Resolution
  - State your commitment to operationalizing BBI principles
  - Receive periodic updates from SAMHSA Child, Adolescent & Family Branch Chief, Dr. Gary Blau
  - Receive advance copies of new resources
  - Sit on national work & task groups
  - Preferential invitation to future BBI summits and forums
  - Enhance your knowledge base & improve outcomes
A third step...

- **Become a BBI supporter** and work towards advancing the field through sponsoring BBI training events, webinars and/or development of documents to support the field. Recent supporters include, but are not limited to:
  - SAMHSA
  - Magellan Health Systems
  - National Association of State Mental Health Program Directors
  - AFYA, Inc.
A fourth step...

• Come to the Building Bridges Initiative (BBI) 2015 Summer Training Event!
• When: August 5 – 7, 2015
• Where: Wyndham Hotel, Andover, MA
• Purpose of Training Event: To support the use of residential and community best practices that result in sustained positive outcomes for youth and families receiving residential interventions and post-discharge. Participants are likely to include leaders and clinical staff of residential and community programs, policy makers, funders, advocates, families and youth.
• To find out more about any of these steps contact Beth Caldwell, Director of BBI (bethcaldwell@roadrunner.com; 413-717-0855)
Other steps being taken in other places...

- Using BBI documents to provide guidance to residential and community providers
- Holding regional and/or statewide BBI forums
- Rewriting regulation/licensing based on BBI principles/practices
- Developing BBI teams and developing plans for state-specific projects
- Revising fiscal strategies to support replication of BBI informed program models
Important BBI documents – available: www.buildingbridges4youth.org

- BBI Tip Sheet: *Youth Advisory Councils*
- BBI Tip Sheet: *Working with and Supporting Siblings*
- BBI Report: *Building Consensus on Residential Measures: Recommendations for Outcome and Performance Measures*
Products/Resources

- Successfully Engaging Families & Youth
- Hiring & Supporting Youth Advocates
- Successful Fiscal Strategies to Implement BBI
- Cultural & Linguistic Competence Guidelines for Residential Programs
- Fact Sheets:
  - Residential
  - Outcomes
  - Community Partners
New Book: *Residential Interventions for Children, Adolescents and Families: A Best Practice Guide*

There are several options for ordering:

- toll free phone: at 1-800-634-7064
- fax: 1-800-248-4724
- email: orders@taylorandfrancis.com
- website: [www.routledgementalhealth.com](http://www.routledgementalhealth.com) (20% discount w/ web orders using code IRK71; free global shipping on any orders over $35)

Orders must include either: the Title: *Residential Interventions for Children, Adolescents and Families: A Best Practice Guide* OR the ISBN: 978-0-415-85456-6

Note: As a federal employee, Gary Blau receives no royalties or any other remuneration for this book. Any royalties received by Beth Caldwell and Bob Lieberman will be used to support youth and family empowerment consistent with BBI.
Building Bridges with Youth and Families: Promoting Youth-Guided and Family-Driven Care in Your Organization

Advancing partnerships among residential and community-based service providers, youth and families to improve lives.
Issues to be aware of:

- Maslow’s Hierarchy (i.e. acuity issues must be addressed first – example of hiring multiple family advocates but program toxic with R/S)
- Watch out for ALL models of care (e.g., Sanctuary; PEM; Love & Logic) “Is it about the program or about the youth?”
- Only models identified to date that are consistent with research on FDC & YGC & TIC: Collaborative Problem Solving (Greene) and Trauma Systems Therapy (Saxe)
- Need leadership expertise in Culture Change (i.e. Six Core Strategies©)
Consistent Challenges Faced

- Other systems (e.g., probation officers; child welfare workers) not supportive of focus on reunification/working w/ family in home/community
- Family Search & Engage/Family Finding/Expanding Support Network—no urgency
- Insufficient community based resources & supports
“You never change things by fighting existing reality. To change something, build a new model that makes the old model obsolete.”

- Buckminster Fuller
BBI Contact Information

- Dr. Gary Blau
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  240-276-1921
- Beth Caldwell
  bethcaldwell@roadrunner.com
  413-644-9319

www.buildingbridges4youth.org
How MA Found its Way to BBI by Focusing on Restraint and Seclusion Use with Youth
Why Start by Focusing on Seclusion & Restraint Use with Youth?

- Restraint use with kids increasing each year
- Population discrepancies (4 - 17x)
- Systemic discrepancies
Seclusion & Restraint Study & Analysis

- Meeting with Providers: “It’s the kids …”
- Analyzing medical records: trauma 87%
- Studying the forms: reactive Restraint Recipe
- Reviewing the literature
- Listening to, valuing, and including youth & families
- Conducting site visits: in vivo exposure to better practice
- Clarifying myths & realities
Pediatric Unit: Post-Visit Restraint Use (07/00–08/02)

Adolescent Unit: Post-Visit Restraint Use (07/00-08/02)
Changing Paradigm & Culture: Sorting Myth from Reality

<table>
<thead>
<tr>
<th>Does not require</th>
<th>Does require</th>
</tr>
</thead>
<tbody>
<tr>
<td>• More money</td>
<td>• Using resources flexibly</td>
</tr>
<tr>
<td>• More staff or new staff</td>
<td>• Core staff, open to change</td>
</tr>
<tr>
<td>• Micro-management &amp; didactic training of staff</td>
<td>• Pragmatic teaching, mentoring &amp; supervision</td>
</tr>
<tr>
<td>• State of art environment</td>
<td>• Flexible use of environment</td>
</tr>
<tr>
<td>• Control / limit setting</td>
<td>• Collaboration / negotiation</td>
</tr>
<tr>
<td>• Strict data collection</td>
<td>• Active use of data</td>
</tr>
</tbody>
</table>
NOW LEAVING

STATUS QUO

"The place that never changes!"

Population
1,000,000
999,999
Multi-Year Strategic Effort

The Goal: Change culture, practice & “root” the Initiative to become sustained culture change

Fundamental Plan

• Build a *S/R Reduction Team*

• Ongoing Action: **SPOTLIGHT & FOOTPRINT**
  - Strategic Planning for DMH & Providers
  - Partnering with Consumers & Families
  - Education for providers/staff: Grand Rounds / Annual Forums
  - Elevating practice standards (regulations / guidelines/contracts)
  - Training & retraining every psychiatric facility/unit in Six Core Strategies©
Statewide C/A Inpatient Services
Reduced R/S Episodes

Episodes Per 1000 Patient Days

- Child Assessment Unit, Camb. Hosp. - Reduced 100%
- Statewide Averages - Child, Reduced 20%
- Adolescent Assessment Unit-Camb. Hosp, Reduced 77%
- Statewide Averages - Adolescent, Reduced 59%
- Child Development Unit-MWMC, Reduced 99%
- Statewide Averages - Mixed C/A, Reduced 75%
Statewide C/A Inpatient Services
Reduced R/S Duration

<table>
<thead>
<tr>
<th>Service Area</th>
<th>2011</th>
<th>2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Assessment Unit, Camb. Hosp. - Reduced 100%</td>
<td>9.73</td>
<td>44.02</td>
</tr>
<tr>
<td>Statewide Averages - Child, Reduced 55%</td>
<td>19.94</td>
<td></td>
</tr>
<tr>
<td>Adolescent Assessment Unit-Camb. Hosp, Reduced 96%</td>
<td>65.04</td>
<td></td>
</tr>
<tr>
<td>Statewide Averages - Adolescent, Reduced 83%</td>
<td>65.66</td>
<td></td>
</tr>
<tr>
<td>Child Development Unit-MWMC, Reduced 99%</td>
<td>47.3</td>
<td>4.71</td>
</tr>
<tr>
<td>Statewide Averages - Mixed C/A, Reduced 85%</td>
<td>30.11</td>
<td></td>
</tr>
</tbody>
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Statewide Reductions for Licensed Facilities

• From 2000 Through 2014:

  - Interventions Reduced 53%
  - Total Patient Count Reduced 36%
  - Total Number of Hours Reduced 80%
Adult State Facility Reductions

- Seclusion & Restraint Hours - 68%
- Episodes - 60%
- # Individuals - 35%
The 2 State Hospitals that Received NASMHPD / OTA SIG Grant Site Visits

Taunton State Hospital
10 adult units, 1 adolescent unit
- 93.5%

Westborough State Hospital
5 adult units, 2 adolescent unit
- 96.9%
But, the Biggest Change: The DMH C/A Statewide Services

- A network of privatized, locked, intensive MH services for most treatment complex & traumatized youth (6-18 yo) in MA
- Previous admission/treatment litmus test driven by pathology/deficit/previous S/R use
- Focus shifted to strengths, skills, future-oriented treatment driven by youth/family goals
C/A Statewide Services Reduced S/R Use

- Mechanical restraint: - 100%
- Medication restraint: - 87%
- Physical restraint: - 50%
- Total S/R time: - 99%
- Avg. S/R duration: - 80%
- Total episodes: - 93%

93% reduction
Child / Adolescent
Mechanical Restraint Reduced - 100%

C/A DMH Statewide Programs: 1999 - 2011
Total Mechanical Restraint Episodes per 1000 Patient Days

# Episodes per 1000 Patient Days

FY 1999

Pre-Intervention

236.8

FY 2011

Post-Intervention

21.2

31.8

0.00

0.00

0.00

0.00
Duration Reduced - 99%

Medication Restraint Reduced - 98%
But a Funny Thing Happened Along the Way ...
## What Else Changed?
### At the Service Level

<table>
<thead>
<tr>
<th></th>
<th>1999</th>
<th>2013</th>
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<tbody>
<tr>
<td>✓ Mechanical restraint</td>
<td>100%</td>
<td>✓ Mechanical restraint</td>
</tr>
<tr>
<td>✓ Seclusion</td>
<td>100%</td>
<td>✓ Seclusion</td>
</tr>
<tr>
<td>✓ Medication restraint</td>
<td>100%</td>
<td>✓ Medication restraint</td>
</tr>
<tr>
<td>✓ Point &amp; level systems</td>
<td>100%</td>
<td>✓ Point &amp; level systems</td>
</tr>
<tr>
<td>✓ Service dogs /pet Rx</td>
<td>0</td>
<td>✓ Service dogs/pet Rx</td>
</tr>
<tr>
<td>✓ Avg. length of stay</td>
<td>406</td>
<td>✓ Avg. length of stay</td>
</tr>
<tr>
<td>✓ Total S/R episodes</td>
<td>6,742</td>
<td>✓ Total S/R episodes</td>
</tr>
<tr>
<td>✓ Total capacity</td>
<td>206</td>
<td>✓ Total capacity</td>
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Closed 6 programs
<table>
<thead>
<tr>
<th>1999</th>
<th>2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>✔ No S/R philosophy</td>
<td>✔ Have S/R philosophy statement</td>
</tr>
<tr>
<td>✔ Policy 15 years old</td>
<td>✔ New policy calls for S/R elimination</td>
</tr>
<tr>
<td>✔ Regulations &gt;10 years old</td>
<td>✔ New regs. on S/R Prevention</td>
</tr>
<tr>
<td>✔ Ltd. Trauma Assessments</td>
<td>✔ Trauma Assessment for all</td>
</tr>
<tr>
<td>✔ No Crisis Planning</td>
<td>✔ Crisis Planning for all</td>
</tr>
<tr>
<td>✔ No Sensory/comfort rooms</td>
<td>✔ Sensory/comfort rooms in all svcs.</td>
</tr>
<tr>
<td>✔ No education on consumer experience or inclusion</td>
<td>✔ Consumers hired &amp; teach staff</td>
</tr>
<tr>
<td>✔ No S/R prevention training or framework</td>
<td>✔ Every hospital &amp; secure treatment facility in MA trained in Six Core Strategies©</td>
</tr>
</tbody>
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Change Ripples Beyond Inpatient Services

- New Interagency S/R Prevention effort is underway to integrate with C/A community-based residential care and public/private schools
  - 7 State Agencies involved & 7 Commissioners sign a Charter to move the state forward together!
What Else is Changing?
At the Community C/A System Level

1999

- No R/S reduction/prevention expectation or framework
- No common R/S definitions
- No youth-guided, family driven framework
- No youth/family requirement re: provider involvement
- No youth/family on staff
- No Family Partners

2013

- All providers must adopt 6CS & have strategic plans if used
- Common definitions in progress
- Residential reprocurement requires Building Bridges framework
- Points & level systems sunset**
- Providers must have family on their Boards & y/f inclusion in service design, delivery & QM
- All DMH IRTPs to have y/f roles
- 300 Family Partners being hired
Critical Factors in Culture Change Process

- **Teaching alternatives**
  - Dispute resolution/mediation
  - Sensory focus & interventions

  *Connecting the mind & the body*

A universal approach to wellness & self-care skill development - learning how to self-calm

Broad application:
- individual
- organization
- environment

*(Champagne & Stromberg, 2004)*
Critical Factors in Culture Change Process

- **Public declaration of values thru standards & statements**
  - “Seclusion & restraint are treatment failure,” and contrary to federal statute governing purpose of inpatient treatment
  - New prevention-oriented:
    - Philosophy
    - Policy
    - Regulations
    - Forms
  - Strategic Plans to reduce/eliminate seclusion and restraint required of all inpatient providers

*(NETI, 2007)*
Critical Factors in Culture Change Process

- Creating written legacies
  - Standards
  - Resource Guides
  - Licensing expectations
  - Contract language & Performance Indicators
  - Y & F Position Statements & Real Danger DVD
Youth & Young Adults Create their own R/S Position Statement
Critical Factors in Culture Change Process

• Creating a service legacy: *preparing workforce gen-next*
  
  – Persons-served participation in service development, crafting positions, & hiring
  
  – Peer-informed curriculum development
  
  – Training / educating *together*
  
  – Create & support Peer roles
    
    • Redeploy $, reprogram vacant positions
    • Ensure Peer leaders at all levels of organization
Critical Factors in Change Process: Families as Partners & Leaders

Colleen Reed (center)
Parent - Consumer Speaker at Groundbreaking Ceremony

Dr. Laura Myers
Dir. of Family Engagement introducing Governor Patrick
Critical Factors in Change Process: Youth as Peer Leaders

Consumers and families are equally represented with elected officials and the average age on the ‘topping off” platform has significantly lowered...
Meet Some of the Groundbreaking Team & Workforce Gen-Next!
To Change Practice, we had to Change our Thinking and Culture.

The Cornerstone of this Change?

Full Inclusion, Partnership & Leadership of Those we Serve
By Paying Attention to What we Were Doing "To" Youth

- WE changed –
and Began to Focus on What we Were Doing "With" Youth
Youth Power Transcends & Ripples

- Shifted our thinking and approach from:
  - “Did we ask the youth?” to “Start by asking the youth.”
  - “Can we organize a youth panel?” to “Let’s develop the agenda with youth, co-welcome, and co-present”
- Solicited perspective, creativity & wisdom:
  - handbooks
  - new roles
  - job descriptions
  - staff hiring & staff training
  - operations, policies & procedures
New & Emerging Roles

- Peer Human Rights Advocate
- Resident Support Team
- Peer Outreach
- Service Review Team
- Service Design
- RFR Review & Contract Award Processes
- Peer Mentors in new community services
- Part of Regional Quality Service Teams
Steps to Formal Role Development

1. Values lead to commitment
2. Commitment leads to decision
3. Decision leads to prioritization
4. Prioritization starts the formal process
5. Process begins with $ identification / allocation
6. Discussion with key constituents
7. Crafting the role (s)
8. Meeting with HRD
9. Vetting the roles
10. Laying the groundwork with care
Making it Real: Lori & Raylena’s Journey
Preparing & Developing Their Talent

- Lori
  - “I was in the hospital for years – that’s where most of my memories were held ... Seven times a day, every day - I spent all my time in the quiet room.”
  - “I was abused as a child so a lot of times it would trigger flashbacks and it would make the situation worse for me because I wouldn’t be able to realize they were trying to help.”

**What she learned:**
- “I would try to get the kid to just stop for a couple of minutes and just try to talk with them and figure out what happened, what caused them to become so angry. If you approach with words, it’s a lot more calm and serene.”
- The staff should try to learn what the kid is all about. The triggers, the warning signs, even just taking a look over the chart to see past behaviors. All of that you can build on to find the underlying problem. Once I find I can establish a conversation if needed, I will try to find a method of distraction for the kid, whether it be sensory, pet therapy dog, Whatever they feel will calm them down and bring them back to where they need to be.
Preparing & Developing Their Talent

• Raylena
  • “I was here for 10 months ... It was not easy.”
  • “I was restrained about 54 times... People don’t learn anything from restraints except that it hurts...” When you scream because you are on the floor getting hurt so bad it triggers other individuals on the unit because they know you are getting hurt, they know what it feels like. It makes them cry, want to hurt themselves, want to get out of that situation. They need out now. It makes the staff feel uncomfortable and upset, they don’t know what to do with themselves
  • I am a Peer Mentor – I love my job.
  • I do a few things with the kids like helping them to cope with things.
Steps to Create Informal Roles

- Ask the youth
- Ask the staff
- Conduct your own gap analysis: where is there a problem, a challenge, a question, a change that is needed?
- Involve the youth in the solution-building process
- Examples:
  - Human rights / complaints overload
  - ‘new kid syndrome’
  - resident support team
The Challenges & Pitfalls

- Aligning $$ and values
- Preparing youth for new roles with ‘professionals’
- Preparing youth for entry into a professional role
- Supervising youth closely
- Teaching to skill & competency development
- Flexible implementation to be fully success-oriented
- Continually monitoring role/implementation
- Starting small & expanding with success
- Measuring to outcomes
- Preparing & supervising non-youth staff
Hiring & Staffing Pragmatics

**Basic Support:**
- flexible hours (no early AM or late PM hours)
- flexible supervision
- regular, weekly access to leadership staff;
- regular, weekly supervision – individual & group
- hire more than one - peer group is essential
- pay for transportation/parking or provide transportation
- pay for travel to conferences, meetings, trainings
- pay for conferences fees
Hiring & Staffing Pragmatics

- **Advanced Support:**
  - Personal growth & development:
    - Teach wellness skills: good self care, hygiene, grooming
    - Assist with how to dress for a professional role, clothing choices
    - Business cards
    - Teaching professional skills
    - Teaching social skills
    - Teaching how to describe and document
    - Encourage and elevate wellness activities
    - Recognizing personal limits and recovery needs
Some Typical Staff Fears

- “You’re actually going to hire them? And you think this is a good thing?”
- “You are going to give them a key?” “What if they lose their key?”
- “How much are you paying them?” “Are they going to get paid as much as us?”
- “They are going into the treatment team meetings?”
- “What about confidentiality?”

Source: Caroline McGrath, UMass Adol. Services, 08/12
Post Implementation Appreciation

- A program without a Peer Mentor asked:
  - “Can we borrow Lori?”
  - “Could she work with one of my kids?”
  - “When are we going to get a peer mentor?”
  - “Can they go on pre-admission meetings with us?”

- The psychiatrists started asking the Peer Mentors:
  - how to better talk with teens about medication
  - how to better understand
  - how to help kids decrease self-injurious behavior.
  - “Can they come to new staff orientation and talk about what it’s like to be in a program?”
  - “Can they..., Will they..., Could we ...?”

Source: Caroline McGrath, UMass Adol. Services, 08/12
The Absolute Joys

- Youth embody hope, recovery, a reclaimed life and the FUTURE!
- Youth transmit service culture and expectations faster than any EBP
- Youth engage peers faster than adults
- Youth can recognize culture obstacles & operational challenges quickly
- Staff quickly appreciate the value of young Peers
- Staff quickly reply on young Peers
- Youth demonstrate: *Ghandi was right*
Alignment & Synergy Between: R/S Prevention, Trauma Informed Care & Y-G, F-D Practice (BBI)

- Evidence to support this orientation
- Empowering, supportive, inclusive of Staff
- Empowering, supportive, inclusive of persons-served & families
- Produces positive outcomes
- Congruent with skill development focused on health and wellness
Alignment & Synergy Between: R/S Prevention, Trauma Informed Care & Y-G, F-D Practice (BBI)

- Culturally sensitive and responsive
- Use of data to drive practice & improve outcomes
- Consistent with systems of care and recovery/resiliency building services
- Result in innovation, creativity and standard of practice advancement
Implementing the Building Bridges Framework: Massachusetts’ Experience
How we got Started

• The Foundation Was Established:
  – Trust and common goals were clear based on prior successful efforts in implementing collaborative assessment project and R/S prevention with BBI & trauma-informed care

• A New Opportunity Arrived: CHAPTER 257
  – Provider litigation for service contract ($) parity & equity required DMH & DCF to recontract residential services. **The agencies decided to recontract together with these shared values and new expectations = Caring Together**
Beginning Steps: We Did our Homework

• Researched, Reviewed, & Analyzed Data to Determine the Needs & Direction
  – Examined National trend data
  – Examined State & Regional information
  – Travelled and met with other states & leaders involved in residential change
  – Examined population data: 5,500 **youth served** each year: 5,000 by DCF, 500 by DMH
  – Examined service data: 69% of residential service providers/contracts ‘map’ to both agencies
  – Examined fiscal data: 240M worth of residential service
Beginning Steps: We Talked A Lot

- Began asking a lot of questions, listening to the answers & most importantly **DOING SOMETHING** with the new information
  - Many focus groups with parents/families & youth (600+)
  - Many focus groups with providers, partners, & other constituents
  - Many focus groups with staff from both agencies
  - Organized youth survey teams & developed tool, met with youth peers in residential services and delivered real time recommendations for service redesign
Providers challenge the state agencies at an early public forum:

“There are a lot of unanswered questions here! It doesn’t sound like the Agencies have this all figured out!”

DMH Deputy Commissioner, Joan Mikula replies:

“Well, we’re building this bridge as we’re walking across it!”
Next Steps: We Identified New Expectations

- **Family-driven, Youth-guided** values & orientation
- **Focus on Permanency from Day 1**
- Trauma Informed Practice
- Goals of **Educational & Community Tenure / Stability**
- **Focus on “Residential” as intervention - not a placement**
- Permeability and portability between levels of service (including residential and community) leading to improved transitions between services
- **Focus on return to community/community-based service**
- Focus on **maintaining family/community connections:** pediatricians, dentists, friends, schools, activities
“We’re no longer interested in simply paying for services – we are interested in buying positive outcomes”
Next Steps: We Prepared Our State for the New Conceptual Framework: BBI+

- Conducted 3 statewide, stakeholder trainings on BBI with national experts – included youth, families, licensors, schools & other agencies & funders!
- Conducted large stakeholder training on implementing the BBI SAT
- Solicited BBI expertise & guidance for consultation in service design / changes
- Issued an RFI looking for feedback on preliminary conceptual framework
- Message saturation & prep. for change:
  - Conducted multiple concurrent Grand Rounds on Y/F inclusion, roles, & perspective
  - Conducted parallel trainings on R/S Prevention/Six Core Strategies©, TIC, & OT
Imbedded New Expectations

- **Youth-guided/Family-driven practice:**
  - Imbedded in programmatic Joint Standards & individual service standards for ALL new contracts/services & new y/f roles in several services
  - Demonstrated through ensuring youth/family perspective and involvement in every step of the process: data collection, service design, service writing, proposal review, proposal selection, contract negotiations and new service implementation
  - Ensured by Creating 4 new regional oversight teams (responsible for: UM, QM, Contracts) with DMH & DCF staff and new team roles: Coordinators Of Family-Driven Practice & Peer Mentors
Made General System Enhancements

• Examples of Requirements:
  – BBI
  – Adoption of Interagency R/S Initiative / Six Core Strategies©
  – Provider Board Members with lived experience (Family/young adults)
  – Families be taught what staff are taught

• Developed/expanded:
  – Family roles / Parent Partners & Youth roles / Peer Mentors
  – OT in intensive services
  – A rate for/budgeting for Service Dogs

• Created new models:
  – to facilitate community transitions & ensure success:
    “Stepping Out” & “Follow Along”
What we Have Learned?

1. We wished we had done this years ago

2. Inclusion of all stakeholders is key – it’s not just about youth/families – it’s about all of us feeling valued and working together

3. We should have planned a larger implementation advisory committee earlier on – anxiety and questions percolated too long. We needed a venue to support providers in the change process in ‘real time’

4. Implementation of the law resulting from the provider litigation (C.257) has made it more difficult to be ‘fiscally flexible’

5. It is very hard work – harder than we thought. Every step is slower but every step is more powerful & impactful – because we are “Caring Together”
What Else we Have Learned?

6. Planning to deliberately become youth-guided, family-driven and change the philosophic framework was much more than a values shift. It forced us to look at EVERYTHING we do. This was unexpected.

7. We had to look at the basics: decision-making for services, how to reconcile protective concerns with consumer choice, and what to do when families do not want y-g/f-d care but want agency-driven decision making.

8. We also had to look at more complex matters, e.g. how to: speak the same language, communicate, and share data with each other: DMH has strict state privacy laws and HIPAA limitations but DCF does not.

9. We learned early resisters think: Y-G/F-D care means “the youth/family gets their way all the time”. This is not so.
Our Strokes of Brilliance

1. Committed to a direction - publically
2. Didn’t profess to have all the answers
3. Planned for a long-term effort
4. Actively and continually (and still do!) solicit feedback
5. Changed our standards to mirror the direction and priority
6. Lived our values: shifted $/resources to create new youth/family roles
7. Connected the effort to all services with a common language and framework
When we commit to a vision to do something that has never been done before, there is no way to know how to get there. We simply have to build the bridge as we walk on it

- Robert E. Quinn -
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