

From Theory to Practice: Residential Care for Children & Youth

Journal Special Edition

Special Edition Vol. 3



ALIGN
Association of Community Services



TOOLE PEET

INSURANCE



**Breaking new ground as insurance brokers and risk advisors.
One client at a time. Every day, since 1897.**

**Specialist in Custom Insurance Solutions for the Social Services
Sector for over 50 years.**

Your world as a provider of social service supports is complicated enough. Cathy Strand, with her over 25 years of specialized insurance experience in the sector understands. She listens to your needs and translates them into the appropriate insurance program for you.

Her claims advocacy and support has made what is a trying time easier for insurance claimants.

Cathy provides risk reduction strategies and she highlights issues that service providers need to be aware of. Because of her background, she provides answers to critical questions before they are even asked!

Cathy Strand, CIP, CCIB

Telephone: 403-209-5433

Email: cstrand@toolepeet.com

1135 - 17th Avenue S.W., Calgary, Alberta T2T 0B6

Toll Free: 1-888-838-6653 Toll Free Fax: 1-877-566-1897 Fax: 403-228-0231

From Theory to Practice: Residential Care for Children & Youth

Journal Special Edition

The ALIGN Journal is published two times a year by the ALIGN Association of Community Services; a membership based provincial organization of child and family service agencies. The Association works to strengthen member agencies and promote attitudes, practices and conditions that contribute to quality service for vulnerable children and families. Articles are the responsibility of the authors and do not necessarily reflect the views of ALIGN.

This particular Special Edition is a compilation of the work that was created and presented at the **From Theory to Practice: Residential Care for Children and Youth Symposium** April 28-29, 2016. The ALIGN Association of Community Services co-hosted this learning event with the Ministry of Human Services. The session was an opportunity for staff of both the Ministry and agencies to come together and learn about several organizational models of residential care and how important it is to use evidence informed practice in our care of these children and youth no matter the environment. We explored how crucial the Foundations of Caregiver Support are and the significance of developing meaningful relationships with the children we care for in order to assist the change process. There was information shared about the effects early trauma and chronic stress has on brain development and how we as caregivers can help undo some of the early harm done to children.

From Theory to Practice: **Residential Care for Children & Youth**

Journal Special Edition

Aims and Scope

This ALIGN Journal will provide an environment for the child, youth and family service sector and other professionals to reflect on policy, practice, training and research in the sector. This Journal will maintain a practice focus using research. It is intended to focus on local and Canadian content. We want to promote best practice in areas that people are working in, and provide room for critical inquiry into some of the promising programs, practice and research that is occurring in the community.

This Special Edition Journal provides papers from individuals who were presenting at the April 28- 29, 2016 Residential Care for Children and Youth Symposium. They are written from a variety of perspectives and based on the shared learning at the symposium. To that end, this particular volume has papers written from their perspective and in their own manner and do not follow the criteria set out for our regular volumes of this Journal. Articles are the responsibility of the authors and do not necessarily reflect the views of ALIGN.

Editorial committee for this edition:

Rhonda Barraclough, ALIGN

Cathy Mitchell - ALIGN

From Theory to Practice: Residential Care for Children & Youth

Journal Special Edition

CONTENTS

Editorial	1
Foundations of Caregiver Support Jon Reeves	
Growing Simple Interactions Inside Everyday Practice Junlei Li	2
What Does It Mean to be Trauma Informed? From the Perspective of the Neurosequential Model. Emily Wang, PH. D., R. Psych.	7
Sanctuary 101: An Overview of the Sanctuary Model Ibet Hernandez	11
The Teaching-Family Model; An Evidenced Based Model Michele Boguslofski	12
The CARE Program Model: Theory to Quality Practice in Residential Child Care Jack Holden and Charles V. Izzo	18

FOUNDATIONS OF CAREGIVER SUPPORT

By: Jon Reeves

Regional Director, Child and Family Services, Calgary Region

Our Vision for infants, children and youth involved with Child and Family Services “is that they are nurtured by empathic, responsive caregivers who accept them as they are, respond to them in a developmentally appropriate manner, interpret their behaviour through a trauma informed lens and have an appreciation for the impact of grief and loss.” Foundations of Caregiver Support – Alberta Ministry of Human Services, 2015.

The Foundations of Caregiver Support (FCGS) builds on Alberta’s Child Intervention Practice Framework, and is intended to ensure all caregivers have common knowledge, understanding and skills to improve the well-being of infants, children and youth involved with Child and Family Services. Put simply, FCGS provides all caregivers with the tools for helping children build healthy brains, reduce trauma, and address loss and grief to improve the well-being of our most vulnerable infants, children and youth in Alberta.

Recently, an explosion of information and research has emerged about brain development in infants, children and youth and how successful intervention can grow brain capacity. The brain at birth is not static - it can be built, that is, new neural pathways generated. Purposeful and skilled interactions -responsive and supportive interactions- between a caregiver and an infant, child or youth have the potential to positively alter their developmental trajectory and improve their health and well-being.

To ensure our interactions are meaningful and aligned, FCGS focuses on four key areas: the core story, child development, trauma and grief and loss. Infants, children, and youth who become involved with Child and Family Services have been negatively impacted by their adverse experiences and these experiences along with their genetic makeup affect their development. Therefore, we need to collectively understand child development in the early years and address the grief and loss children experience when they are removed from their family home.

Finally, as a community of caregivers, we must acknowledge and promote the significance of culture and the paramount importance of connection to family and community in the healthy development of children. This is especially critical in our Indigenous communities. The adversity Indigenous communities and their children have experienced in residential schools, in the Sixties Scoop and in the overrepresentation of their children in child welfare systems across Canada cannot be ignored.

Time is of the essence. We must align our energy and resources as we continue to implement the Child Intervention Practice Framework and FCGS.

The Youth Care Symposium provided many proven and promising approaches to building the brain of a traumatized child. We must continue to move forward in our collective practices.

It is fundamental that we have a collective approach to improve the well-being of infants, children and youth. We have the knowledge and are aware of the skills we need for success. Now, we need the will and determination to act.

GROWING SIMPLE INTERACTIONS INSIDE EVERYDAY PRACTICE

Junlei Li

**Rita M. McGinley Professor of Psychology and Human Development
Fred Rogers Center, St. Vincent College (USA)**

I remember sitting among my fellow panelists at the end of the ALIGN Group Care Conference 2016. Each of us had just been asked to offer our “final words” to summarize what we brought to the conference and what we learned from it. As I listened to the others’ summaries, I realized, belatedly, that I was the only panelist without a treatment or program “model” to offer. These models, like CARE (Children and Residential Experiences) or Sanctuary or CTA (Child Trauma Academy), integrated the elegant and elaborate theories with actionable guidelines for practice. They exemplified the conference theme, “Residential Care from Theory to Practice”. When it was my turn to speak, I sheepishly quipped that I have suddenly developed “model envy”.

In hindsight, I think what I brought to the table is perhaps better described as “from *practice* to practice”. My first encounter with residential care was a very personal one. I adopted my older daughter at the age of two from a state-run Chinese orphanage. I had already been a child development researcher at that time. From the research literature on institutionalized children, I had anticipated that my daughter would exhibit all sorts of developmental delays, particularly in the social and emotional domain (Julian, 2013). What surprised me was the simple fact that my daughter was all right. Yes, she had minor health issues and took a little longer than usual to speak, jump, or run. But she wasted no time attaching and connecting to my wife and, later, to me as well. Even with strangers, it took her about 20 minutes to warm up, and then it would be like “old friends”. Our extended, informal family network grew rapidly not because we were gregarious, but because my daughter was. Why was she “all right” despite two years of residential institutionalization in a setting that was by all means a traditional, unexceptional orphanage?

From day one, the answer was right in front of my eyes (though not quite apparent in my pile of research papers.) A caregiver had handed my daughter to us on the day of the adoption, and while I was interviewing her, I learned the story. This caregiver had been handed the infant two years ago, shortly after my daughter’s birth and abandonment. For two years, my daughter grew up in the caregiver’s ward of 20 plus children. The caregiver described having a “particular soft spot” for my daughter, who had arrived as a premature infant. When the other babies were asleep, the caregiver would walk around with my daughter who did not want to nap. As my daughter got older, the caregiver would enlist her help getting shoes or doing age-appropriate little “chores” for the rest of the babies. Their relationship was special, especially given the context.

I do not want to romanticize the institutionalized setting of orphanages. My daughter’s first two years were not idyllic by any means. The caregiver in question worked long shifts for four or five days a week, and my daughter shared her attention with 20 plus children. Yet what was remarkable was that, even under such conditions, having the semblance of one “normal” relationship seemed just “good enough” for my daughter to turn out all right.

The Active Ingredient

Last year, in the 13th working paper released by the Center on the Developing Child at Harvard University, the following conclusion resonated with the story of my child (markup by me) –

Decades of research in the behavioral and social sciences have produced a rich knowledge base (about resilience) ... the **single most common finding** is that children who end up doing well have had **at least one stable and committed relationship** with a supportive parent, caregiver, or other adult. (Center on the Developing Child, 2015)

Or, to put it more simply, in the words of the children's television host Fred Rogers, the founder of our center and a legacy that began in Canada and is shared by generations of families in both U.S. and Canada:

Human relationships are primary in all of living. When the gusty winds blow and shake our lives, if we know that people care about us, we may bend with the wind, but we won't break. (Rogers, 2003)

It is fair to say that most children who have spent a significant amount of time in out-of-home residential placement have experienced the shaking blow of "gusty winds". For some, such disturbance takes place before their placement; for others, the placement itself may even exacerbate what had already taken place. None of us who work in such setting can undo the "bending", but all of us have hopes that our work may make the difference between "bending" and "breaking".

The theoretical foundation for such hopes seemed fairly clear from the cumulative literature across the different fields of child development. More than a decade ago, the very first working paper from the Center on the Developing Child concluded (markup by me)–

Stated simply, relationships are the **"active ingredients"** of the environment's influence on healthy human development. (National Scientific Council on the Developing Child, 2004)

It took me a good many years before I realized what the phrase "active ingredient" meant. The answer – or rather, the right question – came to me when I was reading the back of a tube of toothpaste (while mindlessly supervising my aforementioned daughter brushing her teeth for the requisite two minutes.) Of the many ingredients that make up a tube, only one was labeled the active ingredient: sodium fluoride. The rest are lumped together under a box called "inactive ingredients".

I wondered how it might work if we compare the work of child development to that tube of toothpaste. If human relationship (the positive, responsive, and caring kind) is the equivalent of sodium fluoride, what might all the inactive ingredients be? I thought of the bubble gum flavor in my children's toothpaste. That was an inactive ingredient, but certainly not a useless one. The flavoring made it possible for children to hold the toothpaste in their mouths for two minutes, which is long enough for the sodium fluoride to do its work to prevent cavities. However, imagine that someone made a tube of toothpaste without the sodium fluoride. In that case, the bubble gum flavor no longer has any benefit. Thus, inactive ingredients are useful if and only if the active ingredient is present. Is that true for child development? Are facilities, staffing, credentials, curricula, activities, and other elements of our institutions and programs useful *if and only if* the active ingredient – positive, responsive, and caring human relationship – is present?

Let us imagine a child who in the course of a day may encounter a number of adults, including parents, teachers, or neighbors. At each of these touch points where adult-child interactions take place, there is the possibility that such interactions can be "developmental" – that is, they help a child "develop". If a particular adult and child consistently have opportunities for developmental interactions day in and day out, a "developmental relationship" may emerge and sustain between them. A setting (program, school, community) where children have one or more developmental relationships with adults could become a "developmental setting". Seeing child development through this lens, the quality of a setting rests on the quality of relationships within the setting, and

the quality of relationships is determined by the quality of everyday interactions between adults and children. As I worked across under-resourced settings, from high poverty neighborhoods and schools to orphanages, I increasingly found the toothpaste analogy to be helpful in understanding what works and what does not (for a more theoretical and empirical review, please refer to Li & Julian, 2012.) More importantly, it helped me understand the experiences and stories shared by those who work in such settings, and how the staff can maintain faith in their profession and hope for the children despite low resources and surrounding adversity.

Growing From the Inside

This naturally leads to two practical questions. One, how do we recognize these developmental interactions in everyday settings? Two, how do we help such interactions grow?

When I worked in the orphanage setting, I initially treated these two questions as wholly separate tasks. I would observe and document conditions in orphanages and see (not surprisingly) the general lack of human interactions surrounding children, particularly those with disabilities. The traditional intervention in that setting is to teach caregiving staff and their administrators of the importance of human relationship in children's development and train them in certain caregiving behaviors that are consistent with that view. In my own work, I gradually realized that the fundamental issue was not that caregivers *do not* believe in the importance of relationships. Most of these women are mothers and grandmothers in their own families and would certainly know and appreciate how to interact with their own children. The real challenge is that caregivers did not know they could interact with children in the orphanage in the same way, given the many institutional constraints that made orphanages so unlike a home. These constraints include high staff and child ratios, frequent changes in *which* staff cared for *which* children, mandated routines that allowed for very little time in being with children (e.g., time-limited feeding), and caring for children with severe disabilities beyond the professional knowledge of the staff (McCall, 2012).

It took me a very long time to realize that the question of “seeing” interactions and “growing” interactions can be woven together in a cycle of appreciation and affirmation. In order to grow interactions, staff needs to see what it is that they are growing, not in abstract or in theory, but in the concreteness of their daily work. Even in settings not typically known for enriched human interactions, like a state-run orphanage, it helps for someone to draw attention to *good* interactions that are already taking place, however small, mundane, brief, and simple such moments may be.

This recognition changed my role from the presumptuous “helpful critic” - who presumes that improvement in a setting is best accomplished through constructive criticism – to that of a “helpful appreciator” – who feels that by appreciating what people *already do well*, we may sow the seeds for growth.

In the orphanage context, this translated into noticing and appreciating the small, ordinary (yet quite extraordinary in essence) things people do with children. Instead of criticizing the fact that each child had less than 3 or 4 minutes of time to be fed, we capture and notice how some caregivers manage to use that small amount of time to interact with the child and help the child to learn to eat on his own. Instead of lamenting the “factory assembly line” procedure for changing children's diapers at the same time of the day (rather than as needed), we capture and notice how some caregivers still manage to make playful games out of diaper change for the children. This does not mean that limited feeding time and assembly line processes are remotely right or appropriate for children – they are not right and they are not appropriate. What this approach means is that we might try to change the larger system by starting with what can *already be done* despite the system, in the hope that small changes can eventually lead us to the question, “what more can be done if we change the system and procedures themselves?”

In our work, we capture such small moments on camera and then, almost without commentary,

we show the video footage to the caregivers and ask them to describe what they see in it. In facilitation, we would reflect back to them what they saw and use as much of their language as possible to describe why such interactions matter. Over the years, we have tried this approach in places as diverse as orphanages, community programs for children with special needs, early childhood programs, schools, and out of school programs. The moments we capture are unscripted, authentic, and often different in each setting. The words and concepts with which people describe such moments may vary, but what remained consistently true is that front-line staff are surprised by the beauty of their own moments of interactions with children. Noticing such moments and talking about such moments with their immediate peers became a touching and affirming experience. You may find a more detailed description of this work at www.simpleinteractions.org and find video examples in early childhood programs at www.everydayinteractions.org.

This type of work is by no means unique in the larger landscape of changing the world. Our work had been inspired by and informed by other similar efforts and theoretical frameworks, such as positive deviance (Pascale, Sternin, & Sternin, 2010, and also see <http://www.positivedeviance.org/>), appreciative inquiry (Cooperrider & Whitney, 2005, and also see <https://appreciativeinquiry.case.edu/>), and community of practice (Wenger & McDermott, 2002, and also see <http://wenger-trayner.com/introduction-to-communities-of-practice/>). Nor is our approach the only way to capture and grow interactions. I imagine there can be many other ways of implementation that highlight the importance of relationships and integrate the knowledge with real, concrete, everyday interactions.

I do think that there is a common guiding principle behind the kind of work that honors and respects the wisdom and commitment of people within the community that care for children (in contrast to approaches that place more emphasis on the wisdom of those “outsiders” who seek to change a community). I think of this as analogous to the workings of a flu shot. As a child, I always found the idea of a flu shot fascinating. What powerful medicine can that one shot contain that would protect me from flu viruses for months to come? A few years ago, a helpful friend explained to me that the flu shot works not because it contained any potent medicine in the traditional sense. Instead, the flu shot contained benign fragments of the flu viruses themselves. The immunization process works because the human body has an autoimmune system that can produce anti-bodies against such viruses. Once “awakened”, the body will continue to produce such anti-bodies, and that is what ultimately protects the body in the months to come. What if our efforts to help a community change work like a flu shot? What if the most potent thing we can do is not to invent or inject some powerful solution from the outside, but merely to trust in and awaken a protective process that already exists on the inside, and one that can keep going long after we (and our resources) are gone? What if we trusted that human beings in any setting have the innate capacity to care for children, and the first and most important thing we can do is to appreciate their capacity, and help them to see that they indeed have such capacity, and help them continue to grow such capacity?

A public school teacher who works in a high-poverty school taught me a new definition of “innovation” – finding something *new* inside something *known*. In the era of “research-based practice”, I wonder if we could create more time and space for “*practice-based practice*” where we take time to recognize what we have *known but taken for granted* in everyday practice under a new, appreciative, affirmative light. I wonder if that is the engine that can drive and sustain changes in an institution as small as a home and community as large as a city or region.

In essence, whether we place our faith in research, or models, or everyday practice (or perhaps ideally, in the balance of all of them), what really matters in our work with children and families is our believing and knowing that our presence can make the ultimate difference.

“I sometimes wonder if, as caregivers, you ever realize how extremely important you are. In the

day-to-day routine ... it's often hard to remember how essential your adult presence is in the lives of the children who come to you for care. Above all, it's your being there that matters most. It's the gift of your honest self that makes the biggest difference in your children's lives.

I thank you for the way you help children feel welcome by the giving of your own special care and by the receiving of the unique care your children give to you. There's no better gift. I wish you well in all the caregiving and receiving of your life."

– A message to all who care for and work with children from Fred Rogers, the host of Mister Rogers' Neighborhood (broadcast in both U.S. and Canada from 1960s through 2000s)

Comments, questions, critiques, and feedback are most welcome. Please contact junlei.li@stvincent.edu.

References

- Center on the Developing Child at Harvard University (2015). Supportive relationships and active skill-building strengthen the foundations of resilience: Working paper no. 13. Retrieved from <http://developingchild.harvard.edu/resources/supportive-relationships-and-active-skill-building-strengthen-the-foundations-of-resilience/>
- Cooperrider, D. & Whitney, D. (2005). *Appreciative inquiry: a positive revolution in change*. Berrett-Koehler Publishers.
- Julian, M. (2013). Age at adoption from institutional care as a window into the lasting effects of early experiences. *Clinical child and family psychological review*, 16(2), 101-145.
- Li, J. & Julian, M. (2012). Developmental relationships as the active ingredient: A unifying working hypothesis of "what works" across intervention settings. *American Journal of Orthopsychiatry*, 82(2), 157–166. Retrieved from <http://www.fredrogerscenter.org/wp-content/uploads/2015/04/Developmental-Relationships-AJO-Li-Julian-2012.pdf>
- McCall, R. B. (2012). Research, practice, and policy perspectives on issues of children without permanent parents. In R. B. McCall, M. H. van IJzendoorn, F. Juffer, C. J. Groark, and V. K. Groza (Eds.), *Children without permanent parents: Research, practice, and policy*. Monographs of the Society for Research in Child Development.
- National Scientific Council on the Developing Child (2004). Young children develop in an environment of relationships: Working paper no. 1. Retrieved from <http://developingchild.harvard.edu/resources/wp1/>
- Pascale, R.T., Sternin, J., & Sternin, M. (2010). *The power of positive deviance: How unlikely innovators solve the world's toughest problems*. Boston: Harvard University Press.
- Rogers, F. (2003). *The world according to Mister Rogers: Important things to remember*. Hyperion, New York.
- Wenger, E., McDermott R., & Snyder, W. (2002). *Cultivating communities of practice*. Boston: Harvard Business Review Press.

WHAT DOES IT MEAN TO BE TRAUMA INFORMED?

From the perspective of the Neurosequential Model

Emily Wang, Ph.D., R. Psych.

The term *Trauma Informed* is widely used, with organizations from across the world striving to become clear about what it means when they make reference to someone who is said to have experienced *developmental trauma*. Developmental Trauma is defined by Dr. Bessel van der Kolk as abuse and neglect that occurs throughout childhood and sets the stage for erratic responses to stress. Van der Kolk further states that this type of trauma leads to increased use of medical, correctional, social and mental health services (van der Kolk, 2005).

Nonetheless, the precise meaning and understanding of being trauma informed continues to be murky. When an organization claims to be 'trauma-informed' we anticipate that they will be more responsive to the impact of trauma but this is not always the case. Furthermore, we would assume that individuals working in a 'trauma-informed' manner with those affected by trauma will have a basic understanding of how trauma impacts one's life; yet again, in our experience this is not always the case. We would hope that a greater understanding of trauma will require the individual and entity to pay attention to organizational elements, program/group care elements, as well as individual elements related to working with traumatized individuals. This means that the more flexible a program is in recognizing the individual developmental needs of the child, the more likely the children in group care settings will experience success (Perry, 2013).

Trauma is complex, and as a result, it is essential to meet the needs of each child by using a multidimensional process, using multiple domains, rather than focusing on one specific form of treatment. In the majority of circumstances children who have experienced complex trauma have challenges across multiple developmental functions, including: Regulatory Functions related to self-soothing (sleep-awake cycle and feeding); Somatosensory Functions (including sensory integration and somatosensory processing); Relational Functions (including issues with attachment, peer and adult relationships); Psycho-Motor Functions (including perceptual, vestibular, fine and gross motor functions); and Cognitive Functions, (including attention, memory, perception, problem solving, speech/language and learning). (e.g., Zarnegar, Hambrick, Perry, Azen & Peterson, 2016).

In order to work more effectively with children who have experienced trauma then, it is necessary to understand development, in particular the development of the brain. A core capacity-building component of the Neurosequential Model (Perry, 2006) involves the basics of neurodevelopment: the brain develops rapidly in utero and continues rapid development in the first four to five years of life. The process of development, along all axis (including motor skills, cognitive skills and social skills) is a sequential process, and brain development is no different. The brain develops from the bottom up through the central parts of its structure to its most complex parts. Fundamental regulatory functions are mediated by the lower—structurally simpler parts of the brain—while the most complex functions, including abstract thought, language and planning, are mediated by the more complex parts of the brain. There is a sequential acquisition of complexity for motor skills, cognitive skills and social skills. Likewise, there is a sequential organization of development of the neural networks that mediate those functions. As the brain develops, the neural networks also become more complex and become more capable of mediating the more complex functions. The success of the organization of the lower parts of the brain therefore impacts the success of the organization of higher parts of the brain. There are neural networks, which include neurons

containing a variety of neurotransmitters (e.g. dopamine, serotonin and norepinephrine) that send connections from lower parts of the brain to the higher parts of the brain. These neural networks occur in target areas and influence development. If something in utero impacts the pattern, frequency and quantity of the neurotransmitters, there will be a measureable difference in the way the system develops. Earlier developmental experiences can have a prolonged and enduring impact of functioning of systems that will manifest and directly send input to higher parts of the brain. Systems that are in dynamic equilibrium are much more sensitive to change than systems that are already organized or developed (Perry, 2006). This is why understanding each child's history is essential for providing truly trauma informed care.

As children develop, they begin to acquire increasingly complex capabilities. This is mirrored in the development of the functioning brain with the neocortex being the most complex and therefore the last part of the brain to develop. The neocortex is uniquely human in that its capacity for abstract reasoning, planning and organizing is so much greater than other mammals. It is the neocortex that allows humans to establish their values and moral beliefs, and as such, it is "the part of the brain that makes us most human" (Perry, 2008).

Entering from the lower parts of the brain, the human brain consistently senses, stores and processes information coming in both from the external world, as well as information provided internally through our body's physiological responses. The brain then begins to interpret and make sense of the incoming information, based on past associations. A past association that was stressful or alarming then initiates an increase in a child's arousal; this is referred to as the stress response system. Similarly, when the brain is faced with something novel, the stress response system is also activated thus moving the child up the arousal continuum (Perry, 2006).

Movement along different states of arousal is typical. Each time we are hungry or thirsty, or each time we go from standing to sitting, we move out of equilibrium and we activate the stress response system. In more extreme cases, the ability to access the smart part of the brain becomes minimal, due to high levels of stress. For example in life threatening situations, our capacity to access the cortex, or consider anything outside of the imminent risk is virtually nonexistent because at that moment, our brain is in pure survival mode. One of the challenges is that there may be many different overt and covert cues (triggers) that can stimulate the stress response system because the brain has made connections between patterns of activity that co-occur. Thus a child's capacity to learn depends on the state that they are in. A challenging transition for one child (e.g. moving classrooms) may not be a problem for another. The child that sees the transition of moving classrooms as a threat will likely become more hyper-aroused, therefore decreasing the child's capacity to function effectively. While these kinds of situations may portray stress as the enemy, in reality, the stress response system requires some activation in order to learn new skills. Essentially, if the stress response system is in complete balance, there is no room for growth or change. By definition, learning requires some activation of the stress response system. The key is the activation of the stress response system in moderate, predictable, and controlled ways. When stress is severe, unpredictable, and uncontrolled, it leads to more vulnerability. Predictable and controlled stress creates more of a scaffold for children to learn, thus building resilience. In order for us to be able to manage our stress most effectively, our stress response system requires the opportunity to return to its baseline. A child who has not had the opportunity to return to baseline will develop a sensitized stress response. Sensitizing experiences result in a neurotypical stress response system becoming overly active at baseline and overly reactive when challenged. A dose of novelty for one child may be overwhelming for another. For all individuals, a return to baseline is necessary before they can be introduced to novel information most effectively.

So how do we, as caregivers teach new skills? How do teachers teach math and reading? How do parents teach social skills, manners, how to tie a shoelace? The capacity for a child to learn

these new skills is impacted by how regulated the child is, or how well the child can manage her stress response system and level of arousal. Since information from the outside world comes in first through the senses, this means that even in the context of teaching a child to read (which requires the cortex), a child's capacity to hear and retain what is being taught depends in part on how regulated the child is when the information is presented to her. Knowing that all information comes in from the lower parts of the brain means that in order for us to access the "smart" part of the brain (cortex) which is required to learn new things, we must "regulate" ourselves first by managing our stress response system in the lower parts of our brain.

Additionally, as we better understand trauma informed care and we consider the essence of our role as caregivers, we must understand that the brain prefers a relationally rich environment. In the history of hunters and gatherers, children were raised by their parents and other adults with up to four adults committed to the care of each child, and as such, the child had rich relational interactions (Ludy-Dobson & Perry, 2010). The capacity to form relationships exists in our genes. Nonetheless, in order to express these capabilities, we require relational interactions. In essence, the neurobiology of attachment is determined by the nature and quality of a child's earliest developmental experiences. Present, attuned, attentive and responsive caregivers can help express a child's attachment capabilities. The vast majority of individuals have fundamental genetic capabilities to make some form of attachment. Attachment is described as a special enduring form of "emotional" relationship with a specific person. It involves soothing, comfort and pleasure, security and safety. Any loss or threat of loss of the attachment figure will evoke distress. Carol George PhD, professor of psychology at Mills College in Oakland, Calif., suggests that children's misbehaviours are often a result of their attachment needs and that lack of attention to these misbehaviors will put the child at more developmental risk. This suggests that attachment needs are state dependent since children will show higher attachment needs in times of distress. As we better understand the stress response system, we come to recognize that as we move up the arousal continuum, our ability to manage our behaviours or "regulate" ourselves diminishes, and misbehaviours often ensue. Our goal in group care then is to recognize the child's attachment needs, and their feelings of safety, rather than consequenceing them for their behaviours. At the Preadolescent Treatment Program at Hull Services, the belief is that the safer a child feels, the more regulated they are, and as a result, they have more access to higher parts of their brain, and can therefore learn new things, be it motor skills, social skills, academic skills, etc. In the context of group care, our status system is based on providing each child with more choices (indicating to them that "your world is larger when you make safe decisions", and that "we would like you closer to staff when you are making unsafe decisions"). The key for caregivers is this: If we know that frightening situations activate attachment at ANY age, we need to ensure that we are increasing our support when kids move up the arousal continuum, rather than meting out consequences for maladaptive behaviours.

So what does it mean to be trauma informed? With the web-based Neurosequential Model metric, we gain a holistic perspective of how the child's brain is functioning in relation to a 'typical' child of the same age range. This perspective is obtained through a detailed clinical reconstruction of the child's history along with information about the child's current behavioral functioning across 32 domains. Developmentally sensitive treatment recommendations are then provided for the child and caregivers across multiple developmental functions. Interventions that are informed by the Neurosequential Model need to occur with high levels of frequency and intensity in order to be effective. Throughout the course of a 24-hour day, the child's developmental needs need to be mindfully addressed by the child's "therapeutic web" (which would include caregivers, community, teachers, family members, and the child herself).

A child who has had a traumatic history has likely had sensitizing experiences, and is therefore more easily aroused than a child who has not experienced such trauma. Thus it is important for caregivers to understand that the child's maladaptive behaviour is not so much a result of the child being "oppositional", manipulative" or "defiant", rather it is more likely a result a sensitized

stress response system. Furthermore, despite the child's significant challenges resulting from adverse childhood experiences during development, relationships create the major vehicle for change, and have the capacity to protect the child from adversity thus suggesting that positive gains are significantly more likely in a relationally rich environment (B.D. Perry, personal communication, March 29, 2016).

References

- George, C. (2014). Attachment Theory: Implications for Young Children and Their Parents. In K. Brandt, B. Perry, S. Seligman & E. Tronick, (Eds.), *Infant and Early Childhood Mental Health: Core Concepts and Clinical Practice* (pp.97-110). Arlington, VA: American Psychiatric Publishing.
- Ludy-Dobson, C. L. & Perry, B.D. (2010). The role of healthy relational interactions in the role of buffering the impact of childhood trauma. In Gil, E., (Ed.), *Working with Children to Heal Interpersonal Trauma: The Power of Play* (pp. 26-43). New York, NY: The Guilford Press.
- Perry, B.D. (2006). The neurosequential model of therapeutics: Applying principles of neuroscience to clinical work with traumatized and maltreated children. In Webb, N.B., (Ed.), *Working With Traumatized Youth in Child Welfare* (pp. 27- 52). New York, NY: The Guilford Press.
- Perry, B.D. (2008). Child Maltreatment: A neurodevelopmental perspective on the role of trauma and neglect in psychopathology. In Beauchaine, T. & Hinshaw, S.P. (Eds.), *Child and Adolescent Psychopathology* (pp. 93-129). Hoboken, NJ: John Wiley & Sons.
- Perry, B.D. & Dobson, C.L. (2013).The neurosequential model of therapeutics. In Ford, J.D. (Ed.), *Treating Complex Traumatic Stress Disorders in Children and Adolescents: Scientific Foundations and Therapeutic Models* (pp. 249-260). New York, NR: The Guilford Press.
- Perry, B.D., (2013). A conversation about trauma and intervention with Dr. Bruce Perry. *Casey Practice Digest, Issue 4: Trauma-Informed Child Welfare*.
- van der Kolk, B.A. (2005). Developmental trauma disorder: Toward a rational diagnosis for children with complex trauma histories. *Psychiatric Annals*, 35(5), 401-408.
- Zarneger, Z. et al (2016). Clinical improvements in adopted children with fetal alcohol spectrum disorders through neurodevelopmentally informed clinical intervention: A pilot study. *Clinical child psychology and psychiatry*, 1-16.

Sanctuary 101:

An Overview of the Sanctuary Model

Ibet Hernandez

Sanctuary is an organizational model of change that is based on the understanding of adversity, trauma and violence. It is a Trauma Informed model that helps organizations transform their healing environment into a trauma responsive environment that approaches its clients and its workforce with the lens of looking at what's happened to people instead of what's wrong with the people we serve and the people we work with.

The Sanctuary Model is built on four pillars: Trauma Theory, The Sanctuary Commitments, S.E.L.F. and the Sanctuary Toolkit.

The objective of the Sanctuary Model for an organization, community, school, residential treatment facility, hospital or any health care system as well as juvenile justice systems is to reduce violence, increase a general understanding about violence prevention and intervention, and increase the level of safety for clients, staff and all who interface with these systems, while building social norms and social cohesion.

Sanctuary begins with sharing scientifically based knowledge about adversity, trauma and violence, how it impacts the brain and affects behaviors. We call this the TRAUMA THEORY. To form a socially cohesive group and establish norms around how we treat each other and agree to engage each other, we must share similar values that become agreed upon anchors for decisions and behaviors.

These values are called The Sanctuary Commitments;

Commitment to Nonviolence, Commitment to Emotional Intelligence, Commitment to Social Learning, Commitment to Open Communication, Commitment to Democracy, Commitment to Social Responsibility and Commitment to Growth and Change.

The knowledge and practice then becomes embedded in a shared language called S.E. L. F.

S-Safety (physical, psychological, social and moral)

E- Emotion Management (not just for clients)

L- Loss (abuse, neglect, separation, getting stuck in repeating the past)

F- Future (how things can be better/ HOPE/ changing the narrative)

The Sanctuary Tool Kit is a practical and operational guideline with specific action plans for putting the knowledge, the values and the language about trauma into action and creating an observable transformed environment able to respond appropriately to the needs of the people it serves and the people who provide the services.

Sanctuary becomes the “way” we agree to operate. The way to understand and respond to the impact of adversity, create connections and empower people by creating environments and dialogues that promote safety, recover, respect and partnerships that will create hope and change.

The Teaching-Family Model

An Evidence-Based Model

Michele Boguslofski

The Teaching-Family Model (TFM) provides comprehensive care as a program model for children, youth and families focused on caregiver relationships and services that are client-centered, strengths-based, trauma-informed, and outcome driven.

The TFM is an evidence-based model, researched since the 1970s, rooted in Behavioral Principles and Social Learning Theory. Relationship-based care is paired with a cognitive behavioral approach that promotes best practice for creating positive, sustained change and healing.

Developed in 1967 at the University of Kansas, the TFM is the result of the efforts of a strong team lead by the founder of applied behavioral analysis, Dr. Montrose Wolf. Dr. Wolf, alongside Dr. Lonnie Phillips, Dr. Dean Fixen, Dr. Gary Timbers, and Dr. Karen Blasé, collected and studied data, informed and refined best practices, and developed fidelity measures, approaches, and systems to strengthen practice and improve outcomes for children, youth and families.

With a focus on developing people (caregivers), they had a remarkably strong effect on practices and processes, and were able to establish systems of training, consultation, and evaluation leading to essential and authentic replication and dissemination of the TFM across caregivers, administrators, programs, and regions, leading to a full system-of-care approach.

This approach focuses on fidelity and recognizes that practitioners/caregivers are the key to successful implementation. Hence, tools for practitioners, organizational systems for supervisors, trainers and administrators, a culture supporting philosophy and values, and quality assurance are built into the TFM to ensure congruence and help all persons be the best they can be.

The research history behind the TFM encompasses the evolution of the Bureau of Child Research and the Department of Human Development and Family Life at the University of Kansas. The National Institute of Mental Health provided research funding for two decades, and remains intimately involved and interested in the TFM.

Following the opening of the initial program for boys in Lawrence, Kansas, over 200 individual experimental studies were conducted in Teaching-Family group homes. These studies were employed within subject experimental designs and focused on direct observation of youth behavior and the behavior of practitioners, with the first priority always being the benefit and effectiveness for youth being served. Additional research papers and data can be accessed via a TFM bibliography at <http://teaching-family.org/wpcontent/uploads/2013/10/tfabibliography.pdf>

Recent research findings incorporate significant longitudinal studies and research by Elizabeth Farmer and others support improved outcomes and overall effectiveness in TFM programs. Examples of research and strong outcome data and findings include:

1. Improvement of Psychiatric Symptoms with significantly better SDQ (Strengths and Difficulties Questionnaire) scores post-discharge (Farmer et al., 2016).
2. Decrease in Negative Post-Discharge Outcomes with clients five-times less likely to be readmitted to residential care and three times less likely to drop-out of school (Trout et al., 2013).

3. Adult Rate of Interpersonal Violence for youth who had experienced significant childhood trauma up to 16 years post TFM is on par with the general population (normative) breaking the intergenerational cycle of violence (Huefner, et al., 2007).

4. Positive Impact on School Performance evidenced by improved grades – in most cases by a full grade point average, higher rate of school graduation, and increased likelihood to access secondary education (Thompson et al., 1996).

TFM agencies and programs provide solid evidence-based solutions for treatment and care and are linked to the California Evidence-Based Clearing House (CEBC) already rated for higher level of placement and parent training and under consideration for higher ranking and to the National Registry of Evidence Based Programs, and Practice (NREPP), having passed through the first phase of approval. The TFM is promoted by the American Psychological Association (APA) as an evidence-based best practice, by the US Office of Juvenile Justice Delinquency Prevention, and the US Surgeon General and is an example of research that has been transmitted to the field to benefit large numbers of children, youth, and families.

The TFM is comprised of best practice standards, all of which are least invasive and most inclusive. These standards serve as benchmarks for exceptional service, programming, and care, and include Goals, Elements, and Integrated Systems. Every agency and organization associated with and accredited by the Teaching-Family Association must demonstrate their adherence to and implementation of every standard that comprises the TFM. Goals include:

Humane	Teaching-Family programs demonstrate compassionate, considerate, respectful, and unconditional positive regard for all clients with no tolerance for abuse or neglect.
Effective	Outcomes are observable and measurable. Clients and staff acquire skills necessary to achieve their goals. The quality and stability of staff are maintained to ensure effectiveness.
Trauma-Informed	The Model ensures the realization of the prevalence of trauma, recognizes how trauma affects all individuals involved in the program including staff, and responds by fully integrating knowledge about trauma into policies, procedures and practices. Trauma-informed practices for practitioners, clients and families are woven into the
Individualized	Services provided by Teaching-Family Association agencies are client-centered, strength-based and directly related to the unique needs of the client. Services are culturally sensitive, developmentally appropriate, and provided based on an individual’s unique characteristics, strengths and vulnerabilities.
Consumer Satisfaction	Opportunities are provided for client and stakeholder input. Clients and consumers express a high degree of satisfaction with the services provided. Quality assurance processes incorporate consumer feedback.

Specifically examining the application of the TFM with persons who have been exposed to trauma, and in trauma-informed environments, underscores the conclusive, positive outcomes that are realized and achieved with the implementation of a research and evidence-based model. The effects of trauma exposure are vast and may include indicators in the areas of attachment, biology, mood regulation, dissociation, behavioral control, cognition, self-concept, and development, and impact long-term social, emotional, health and overall well-being.

Responses to the same or a similar event may vary greatly based on factors such as age, developmental stage, previous trauma history, status as a victim or witness, relationship with the perpetrator or victim, perception of danger faced, and the presence of an adult, or adults, who can help and provide support. Furthermore, separation of the family following traumatic events causes greater impact, grief and loss. Individualized assessment, care, and strategies are necessary to effectively attend to the child or youth's trauma and to address possible historical trauma as it relates to the collective and cumulative emotional wounding across generations, and the cumulative exposure to traumatic events that not only affect an individual, but continue to affect subsequent generations.

The TFM is designed to work with the brain, repairing trauma's negative impact through positive, corrective experiences. Taking advantage of the brain's plasticity, the TFM is able to train the brain, build new connections, and help individuals establish strong synapses through repeated exposure to enhance brain development around healthy behaviors and skills helpful in addressing and working through trauma.

Extensive and ongoing brain research proves that brain development continues through adolescence and young adulthood, and that regardless of a person's age, the brain changes. Neural pathways that are used most often become the strongest, and with repetition, role-plays, teaching and doing, learning and practicing the brain can learn new ways of responding.

This supports emotional regulation and enable an individual to move from maladaptive coping strategies (based on their response to trauma) such as sleeping and eating disruption, emotional detachment, depression, anxiety, heightened fight or flight, acting out and excessive risky behaviors to more beneficial and helpful behaviors that promote safety, permanency, well-being, and build sustainable resiliency while increasing positive opportunities.

The TFM creates positive change and healing from the effects of trauma through caregiver relationships and teaching, using a "serve and return" approach with people they trust, and know care about and value them.

Elements of the TFM are at the core of the work and treatment being done. Elements are:

Teaching

Observe, describe behaviors in an objective, supportive manner; identify strengths and areas of skill deficits; role-plays; strategies to manage intense and maladaptive behaviors; pro-social skill development and acquisition; support emotional expression; regulation skills and anxiety management and related skills. Cognitive behaviorally-based interventions; safe, nurturing interactions that are predictable and consistent.

Therapeutic Relationships	Healthy, nurturing relationships focused on belonging, connectedness, identity, safety, trust, respect, consistency and caring. Positive interaction, sensitive and responsive, encouraging; not judgmental. Supportive role models, teachers, and mentors. Time spent doing and being together.
Self-Determination	Provides and promotes empowerment over personal choices, consequences of decisions; personal contributions and the ability to have impact; leadership; personal control, input into decisions, treatment, goals, and their future; builds on abilities, strengths, interests, and passion.
Family-Sensitive	Promotes and advocates for client and the client's family; family involvement to the extent it is appropriate (safe); facilitation of family interaction and connectedness; family-welcoming and inclusive environment; ongoing communication and involvement.
Diversity	Ethnic and cultural connections, celebrations and ceremony; respect for and of differences; opportunities to participate in activities and events that promote and reflect diversity of individual clients.
Professionalism	Ongoing training and consultation for skill acquisition and development of practitioners; association certification of and for practitioners; participation in and leadership on treatment team and as an advocate for clients' needs.

The TFM builds sustainability and resilience in agencies, programs, staff, and clients via its Integrated Systems. These systems provide the framework for quality assurance and model fidelity, support practitioner skill development and therapeutic outcomes, ensure program and agency accountability, and provide process and outcome data.

At the heart of the model are children, youth and families, followed by practitioners, and then by the organizational approach of four (4) Integrated Systems: Facilitative Administration, Training, Consultation/Supervision, and Evaluation. Qualified trainers, consultants and supervisors, evaluators, and administrators provide oversight and comprehensive integrations of these systems within agencies, programs, and within the association.

Facilitative Administration ensures the values and principles of the TFM permeate all levels of the organizational culture and adherence to its Standards of Service. Those responsible for Facilitative Administration at their agency work to provide the resources necessary for all the goals, systems, and elements to work together to support best practice and client-centered outcomes.

TFM Training is competency-based and is designed to build practitioner skills, knowledge and expertise. Training includes theory and application of knowledge in classroom discussion, testing, role-plays, and homework. Staff are empowered to focus on the mastery of required skills and the selection of staff is key to ensuring both quality and integrity of practitioners and programs. TFM training maintains the fidelity of the model at the direct care level and provides a platform for ongoing training, consultation, and evaluation.

Consultation/Supervision is a systematic approach to skill development and safeguards against drift. Direct observation and feedback are used to provide valuable knowledge regarding implementation of training and treatment. Support and crisis response are delivered 24/7 to ensure treatment continues at all times. Individualized treatment planning is overseen, with input from the client, family, and entire treatment team. The consultant/supervisor pays careful attention to the environment and relationships paired with the TFM's evidence-based practices provided in training.

Lastly, Evaluation upholds quality of care for practitioners, programs, and agencies culminating in an International Certification of Practitioners (annually) and International Accreditation of Agencies (triennially). Evaluation of Model implementation and Standards of Service are reviewed by independent reviewers; program outcomes are also examined.

Every TFM Standard of Service has compliance indicators and measures. Evaluation activities, culminating in Certification of Practitioners and Agency Accreditation, are conducted by formally trained and vastly experienced teams. Review teams are on-site at the agency undergoing review for several days, examining all the compliance indicators and measures established for every Goal, Element, and System, laying eyes on clients and practitioners, and reviewing data. Drilling down into the Trauma-Informed Standard, indicators of compliance that are included in formal review include:

- Agency and program environments assure the safety of and respect for all clients.
- Program participants are screened for histories and symptoms of trauma.
- Staff are trained about the impact of trauma and the prevalence of traumatic histories in the lives of persons and populations they serve. Training includes understanding caregiver perceptions, responses and what is helpful.
- Program participant histories inform the planning and delivery of services in order to strengthen their resilience and protective factors, and help guide the pathways to address grief and loss when appropriate.
- Behaviors are addressed through teaching and relationships with a trauma-informed lens, ensuring healthy responses that promote increased positive social and emotional development and connection.
- Programs work collaboratively with clients in a way that empowers them and meets their need to be informed, connected and hopeful.
- Agency has an established environment of care that increases staff resilience.
- Staff respect and value all children, youth, and families, meeting them where they are and embracing self-concept and identity.

The TFM is not proprietary; it is designed to inform and respond. Program quality, quality of practitioners, and sustained outcomes for children, youth, and families are priorities for those who deliver this evidence-based model. Agency Accreditation and Practitioner Certification are based on quality of care – for clients and caregivers, and fidelity, integrity, effectiveness of services, and treatment outcomes.

A replicable and sustainable model - with certified sites across the United States, in Canada and New Zealand--and developing sites in Albania, Denmark, the Netherlands, and Japan—the Teaching-Family Model continues to adapt successfully to new treatment environments and popula-

tions. TFM agencies are committed to evolving the knowledge, practice, and adaptability of this model to a broad range of populations, programs, and cultures.

The CARE Program Model:

Theory to Quality Practice in Residential Child Care

Jack Holden, Bronfenbrenner Center for Translational Research (BCTR), Cornell University;

Charles V. Izzo, Bronfenbrenner Center for Translational Research (BCTR), Cornell University

Abstract

This report summarizes the presentation that was delivered on April 29, 2016 at the ALIGN conference in Edmonton, Alberta. The first section describes the CARE model of practice (Children and Residential Experiences), and the model of implementation. The second section summarizes the results of a multisite study of CARE implementation in the USA.

CARE is a principle-based program that helps agencies use a set of evidence-informed principles to guide programming and enrich the relational dynamics throughout the agency. CARE aims to enhance the [therapeutic environment] in group care agencies by improving the quality of relationships and interactions among youth and adults.

Thirteen agencies in North Carolina implemented CARE for three years. Agencies provided administrative data about the monthly rate of several serious behavioral incidents. Also, each year all eligible youth were surveyed about their relationships with caregiving staff using a revised version of the Inventory of Parent and Peer Attachment, revised for the group care population.

Using linear mixed models, we assessed program effects by comparing the changes in attachment among the first cohort of CARE agencies with a second cohort of equivalent agencies placed on a 12 month wait list before initiating CARE.

Findings suggest that implementing the CARE program model can improve the capacity of staff to establish positive attachment relationships with the youth in their care.

The CARE Program Model: Theory to Quality Practice in Residential Child Care

The population of youth living in residential care has a disproportionately high rate of emotional and behavioral problems (Burns et al., 2004) and is at high risk of experiencing poor developmental outcomes throughout the life course. In addition to experiencing parental maltreatment and other forms of trauma, young people in group care often have a history of unsuccessful placement in foster care (Zinn, DeCoursey, George & Courtney, 2006), and a host of other risk factors that impair their healthy development (Ryan & Testa, 2005). Youth in group care typically receive some form of treatment by professional clinicians. Equally important, however, is their need for healthy developmental experiences throughout the day, and to be protected from experiencing additional trauma and other toxic experiences in the residential setting. In other words, they need to live within a therapeutic social milieu that supports their rehabilitation (James, 2014).

The current paper reports results from two studies examining the impact of Children and Residential Experiences (CARE), an intensive, principle-based program model designed to help organizations create more therapeutic care environments to enrich the day-to-day experiences of youth placed in out-of-home care. CARE is based on well-established scientific evidence about the developmental and relational needs of youth who experience trauma and other stressful experi-

ences associated with placement in out-of-home care (Holden, 2009).

CARE OVERVIEW

Children and Residential Experiences: Creating Conditions for Change (CARE) is a multi-level program for improving services in out-of-home care (Holden, 2009). CARE was developed at the Residential Child Care Project (RCCP) in the Bronfenbrenner Center for Translational Research (BCTR), Cornell University. The underpinnings for the development of CARE can be found in the developer's realization that organizations that had strong practices did far better implementing a crisis intervention system, such as Therapeutic Crisis Intervention (TCI) (Holden et al., 2009), than those with no program model.

After more than 20 years of successfully delivering the TCI program the RCCP began studying the possibility of developing a program model that would enable child caring agencies to organize and deliver quality care of children according to research-informed principles based on the best interest of children. In collaboration with the South Carolina Association of Children and Family Services (SCACFS), the Duke Foundation, and Cornell University in 2005, research and curriculum development began. Basic and relevant best practices competencies determined by national and international standards were integrated along with qualities of strong programs determined through Jim Anglin's research (Anglin, 2002) and national and international standards. The CARE program model began piloting with seven agencies from North and South Carolina in 2007 that were subsequently studied. Additionally several other agencies that were looking for a new and research informed or based program model chose to implement the CARE practice and the "rest is history".

The CARE program model is founded on six research and standards-informed principles designed to guide residential child care staff's practice and interactions with children and families in order to create conditions for positive change in children's lives. The research-informed principles support care and treatment that is developmentally focused, family involved, relationship based, competency centered, trauma informed, and ecologically oriented. These best practices are grounded in theory, in evidenced based practices, in practice wisdom, and in quality child care standards. The principles were established after literature reviews, surveys of experienced caregivers, supervisors, and leadership and from standards review.

The core challenges for agencies implementing CARE are "achieving congruency throughout the agency in serving the best interests of children", therefore the basic principles apply at all levels of the organization. This concept although seemingly embraced by most organizations presents challenges for many because of the dynamics operating at all levels of any organization. The core concepts include "best interests of the child, struggle for congruence, and evidence informed practice" (Holden, Anglin, Nunno, & Izzo, 2014). Congruency calls for reciprocity in the interactions among all persons. Consistency is when all working in an organization have the same set of values, principles, and actions demonstrated over time and at all levels. Coherence means that overall patterns of actions are cohesive and have integrity (Anglin, 2002). Evidence informed practices are based on existing research and best practices, have a set of principles that guide policy, procedures, and practices, and a well-articulated, evidence-based theory of change (Lee & Barth, 2011).

The purpose of residential care is to provide, a sense of breathing room for the child and family, a safe place for children and families to learn new skills and adults who act as teachers, coaches, and mentors to help develop and practice necessary life skills. Another important purpose is to help children realize a more normal developmental trajectory. The six CARE principles support the provision of quality residential care, and help an organization meet the core challenges and integrate core concepts.

Relationship Based

Research indicates that the ability to form relationships is associated with healthy development and life success, developmental relationships are central to helping children develop and building competencies, and that children respond most to people they trust.

Practice implications for relationship based include taking time and developing skills to build attachments and relationships with the children, protecting the relationship between the child and worker/teacher/carer, and identifying relationship building as a primary job task for staff. Because the principles apply to all levels of the organizations the following are some of the questions to raise when considering the relationship based principle: *What kind of relationships do the adults at your agency have with the children in care and with the families of children in care? What kind of relationships do the supervisors have with their staff and administrators with staff? What policies address relationships? Do job descriptions and performance evaluations focus on relationships as a primary function of the job? What would people say about their tasks and roles in regard to relationships?*

Developmentally Focused

Research indicates that all children have the same basic requirements for growth and development, children learn best when skills are within their zone of proximal development, and children need support to engage their innate capacity to grow and develop. *Developmentally Focused* practice implications are for staff to teach developmentally appropriate skills, provide opportunities to practice newly learned skills, adjust activities so children can succeed, and create opportunities so that children's innate capacity to develop is engaged.

Questions for organizations to ask are, what is meant by *"zone of proximal development and how do we support staff with children's skill development?"* *Do we provide staff development opportunities to increase staff's ability to deal with complex situations? Do we provide staff opportunities to grow within their zone of proximal development?*

Family Involved

Research indicates that family contact has demonstrated positive outcomes for children, planning for adequate community support is essential for a successful return, and the child's ethnic and cultural identity is tied to the family. Family Involved practice implications are, partner with families so they have access and input into the child's life, understand and respect the family's worldview, support the child's relationship with the family, and develop culturally competent staff. Questions for organizations to ask are, *how important is the family in a child's life? How do we keep the child connected with his or her community and culture? Do we hire and/or develop staff to be culturally competent? Are family's true partners in the care and treatment of their children?*

Competence Centered

Research indicates that problem solving skills, flexibility, critical thinking, emotional regulation, and insight are necessary life skills, focusing on strengths and positive attributes builds a positive identity, the child's personal strengths and resources are the biggest factor in making positive change. All these contribute to a child's resiliency and their ability to succeed. Competence Centered practice implications consist of matching a child's activities and expectations to the individual child's strengths and abilities to succeed, teaching life skills by ensuring that all interactions and activities are goal oriented and focused on teaching skills, and sending high expectation messages to children and help them meet expectations. Moreover the development of competence is dependent on the developmental relationship, cognitive functioning and self-regulation. Questions for organizations to ask are, *do the adults working with the children have the skills we*

ask them to teach to the children? What skills do we presently focus on when planning children's activities and routines? What strategies do we use to teach children these skills? What opportunities do we provide for staff to develop their abilities to teach children skills?

Trauma Informed

Research indicates that trauma has a debilitating effect on children's growth and development, that maintaining a non-coercive and a safe environment is essential for children to learn new responses to stressful situations, and that challenging behavior is often pain-based behavior. In recent years, understanding the effects of trauma has become a focus for residential care providers as researchers continue to discover more about the effects of trauma on brain development. Trauma Informed practice implications include providing a consistent, predictable environment, building relationships that are based on trust and respect, providing activities that are future oriented and allow children to contribute, and avoiding events and environmental factors that might trigger a stress response. Questions for organizations to consider are, how many children in your care have experienced emotional, psychological and/or physical trauma in their lives? How has this affected their development? What is meant by pain-based behavior? How can this principle keep us focused on providing order and learning experiences versus demanding compliance and control? How do we try to prevent secondary trauma and staff burn out? How does the organization 'hold the direct caregivers and counseling staff'? Ecologically Oriented

Research indicates that children learn through interacting with their environment, the environment is influenced by the interactions with the children and adults, and environmental factors that protect children are; caring relationships, high expectation messages, opportunities for contribution & participation.

Ecologically Oriented practice implications include, designing the program so that children can successfully meet expectations and participate fully, adjust activities so that children can succeed and progress, motivate children to participate, to get involved and interact with adults and peers through the social and physical environment. Questions for organizations to ask are, *why should we look at the environment when a child is struggling to meet basic expectations? How many people and systems make up a child's world? How do we create an environment where we learn with each other?*

For an agency to implement and integrate the CARE program principles into their organization, there are several characteristics of the CARE approach to consider. First, the agency is the locus of learning and the agency itself becomes the primary learning site, second, the agency is the unit of learning, rather than the individual (or even the team) and third, the facilitation process involves much more than skills training or knowledge transmission (Anglin, 2011). The implementation process uses CARE consultants who become engaged in a co-learning and co-creation process alongside the agency staff members; all participants are learners. CARE consultants work to realize the potential of adult learners and to align their mindsets with the needs and experiences of the children.

Program Implementation

A pair of CARE Consultants works with each agency for three years to help them re-orient their practices around the six evidence-informed principles described above. For most agencies, this process calls for changes in theoretical perspective, organizational norms, and role expectations. An essential implementation activity is the development of a CARE Implementation Team (IT) that includes agency leadership, supervisors and key training and clinical staff. Its role involves providing support, modeling and mentoring to staff as they incorporate CARE principles into their work. The team also builds structures and processes that facilitate application of the CARE principles and their eventual integration into the agency culture.

The leadership and ITs are trained in the CARE principles through a five-day manualized program and a group of agency based trainers are prepared to deliver the same 5-day training to remaining staff. CARE Consultants provided quarterly on-site technical assistance (TA) visits to implementation teams and other agency staff. TA activities involve observation and feedback, training and coaching for front-line supervisors, developing routines for reflective practice, and addressing organizational barriers to creating a more therapeutic milieu.

Finally, implementing CARE involves “changing the entire operating system” i.e., the training is focused on changing a mindset, not about simply adding new information or developing new technical skills. The emphasis is on transforming the organization as a whole, and implementation is approached as a marathon, not a sprint.

Below we report a longitudinal study examining the effects of implementing CARE at multiple agencies over a three year period. Note that all results reported here have been reported in other journal articles and conference presentations.

Central research questions:

- To what extent does implementing CARE at residential childcare agencies lead to fewer serious behavioral incidents?
- To what extent does CARE implementation lead to improved relationship quality between youth and direct care providers?

Method

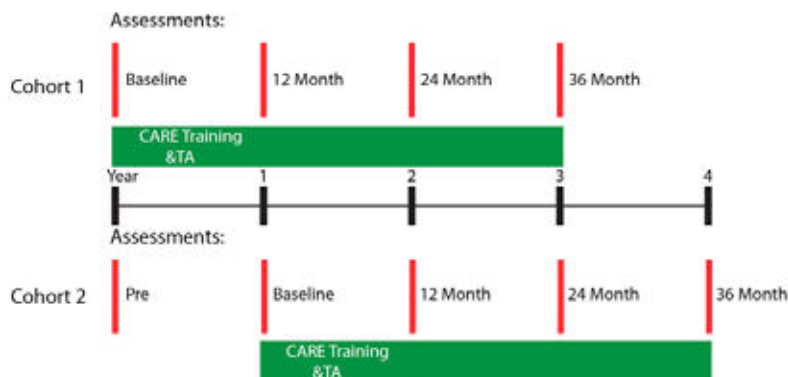
Participating Agencies

Sixteen agencies initially committed to participate, of which 7 were assigned to begin CARE immediately (Cohort 1), and 9 waited about 12 months before beginning CARE implementation (Cohort 2). During the study period, one agency became ineligible due to a change in target population, one closed before implementation began, and one discontinued due to change in administrative priorities.

At the start of CARE, the average number of residential staff at these agencies was 13, and the average number of youth was 24, resulting in an average youth to staff ratio of 1.81. Most agencies typically served youth from 7 to 18 years of age; Most served both males and females, and one agency served only males. All agencies previously relied on homegrown programs (e.g., point and level systems, enrichment activities) but had no coherent model that guided daily childcare practices and organizational management.

Data Collection

Collection of survey data from staff and youth occurred annually. As shown in Figure 1, Cohort 1 received one baseline (2009) and Cohort 2 received two baseline assessments (2009 and 2010).



Measures

Behavioral Incidents. Agencies provided monthly behavioral incident data from their administrative records during the baseline and implementation periods. Each year, agency quality assurance staff were asked to count the number of incident reports filed in the previous year, indicating the monthly frequencies for each of five incident types: verbal threats or physical aggression toward staff, verbal threats or physical aggression toward peers, an act or threat of self-harm, property destruction, and attempted or completed runaways. Incidents involving multiple residents were counted separately for each resident, unless the resident was only a victim in the incident.

Organizational Social Context (OSC). The baseline staff assessment included the OSC survey, which assesses dimensions of culture (proficiency, resistance, rigidity) and climate (stress, engagement, functionality) at the agency level (Glisson & Hemmelgarn, 1998). Following Glisson, Hemmelgarn, Green, and Williams (2013), agencies were classified into one of three profiles (1=negative, 2=average, 3=positive) based on the pattern of scores across the six subscales. Negative profiles reflect lower scores on engagement, functionality, and proficiency and higher scores on stress, resistance, and rigidity. Positive profiles reflect an opposite pattern of subscale scores.

Youth Adult Relationship Quality. All residents age 8 and older were asked to complete a survey about their relationships with staff called the **Inventory of Parent and Peer Attachment (IPPA)**, Armsden & Greenberg, 1987). This self-report instrument measure the cognitive and affective dimensions of the relationships between adolescents and either parents or peers. We adapted the original parent version by rewording items to more accurately reflect residents' circumstances (e.g., referencing direct-care residential staff rather than "parents"). Because a respondent's relationship was likely to differ across caregivers, we changed the response choices from a 5 point agree/disagree scale to the following scale asking how often the respondent felt this way about residential staff members at their cottage over the past month: 1=never, 2=rarely, 3=sometimes, 4=often, 5=always. Respondents were asked to answer thinking about all direct care staff at their cottage, which usually included two pairs of caregivers that worked alternating one or two-week shifts.

A member of the research team met annually with all residents whose parents or legal guardians had provided written consent, explained the study details, and administered the survey by reading the items aloud to small groups of youth. For various reasons, this format was not possible for 16% of respondents, and a clinical case manager at the agency was asked to provide youth with a private space to complete the paper or on-line version of the survey.

For Cohort 1 agencies, annual youth surveys began about 4 weeks prior to CARE initiation. For Cohort 2 agencies, surveys began about 12 months prior to CARE initiation.

Assessment of staff characteristics. Staff surveys were administered anonymously to all agency personnel 2-4 weeks prior to the first training session. Most 92% surveys were administered on paper by research staff at agency-wide meetings with 8% being self-administered online or mailed in for those not present on survey day. Respondents were informed that their survey data would not be linked to their identity and that no agency personnel would ever see them. Survey questions asked about demographics and their perceptions about organizational climate and culture.

Study 1: Effect of CARE on Behavioral Incidents

To test the effect of CARE implementation on behavioral incidents, we used an interrupted time series design (ITS) (Shadish, Cook, & Campbell, 2002). Specifically, by obtaining multiple base-

line assessments ITS was used to examine how CARE implementation was related to changes in the frequency of behavioral incidents in two successive cohorts of agencies. Specifically, we compared incident rates in the 12 months before implementation (baseline period) to rates in the 36 months during implementation (implementation period). Comparing the trends between the baseline and implementation periods, helps us be able to rule out the possibility that any changes we see during implementation were simply the continuation of existing trends. Data for this study came from the 11 agencies that remained in the study and for whom the collection of incident data was consistent and detailed enough to be aggregated together for analysis.

Data Analysis. The details of the analytic strategy are described in Izzo et al (2016). For each of the five types of behavioral incidents, we constructed a mixed effects negative binomial regression model to estimate the number of behavioral incidents per resident per month. Each model estimated [an intercept and] two slopes, or time trends: one for the baseline period prior to CARE (Months -12 to 0) and one for the program implementation period (Months 1 to 36). We tested for a program effect by comparing the difference between the trends during the baseline and implementation periods. Covariates were added to the model to adjust for variations related to cohort and OSC profile score.

Study 1 Results. During the baseline period, there was an increasing trend for Aggression toward Peers, Aggression toward Staff, and Property Destruction for Cohort 1, which occurred in 2009. In Cohort 2, for whom the baseline period was in 2010, an increasing trend was evident for Property Destruction, and other incident types showed no change. During CARE implementation, the incident rate declined significantly for all outcomes.

The program effects for each incident type are represented as the difference between the trend estimates during the baseline and implementation periods. For three outcomes (Aggression toward Staff, Property Destruction, and Runaway), there was a declining trend during implementation, and it was significantly different from the baseline trend, as predicted. These results were the same for both cohorts. This same pattern was observed for Aggression toward Peers and Self-Harm, but only in Cohort 1 agencies.

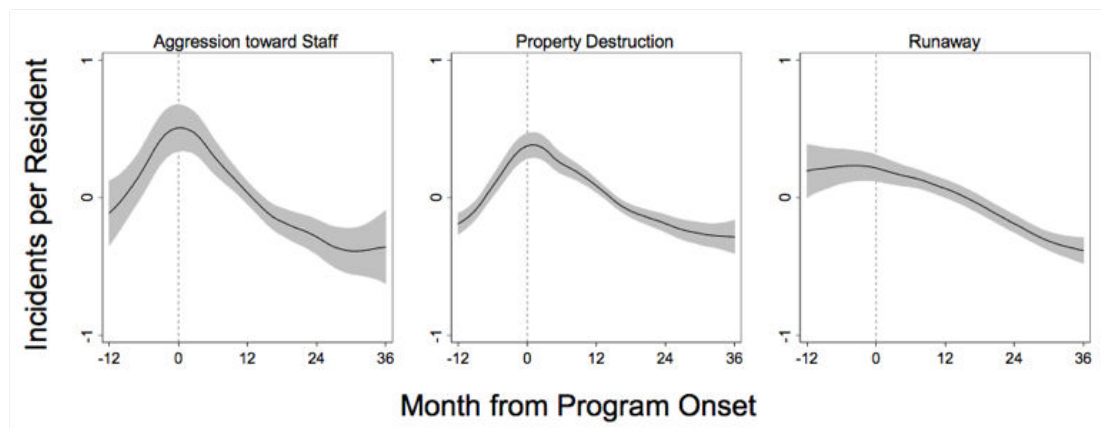


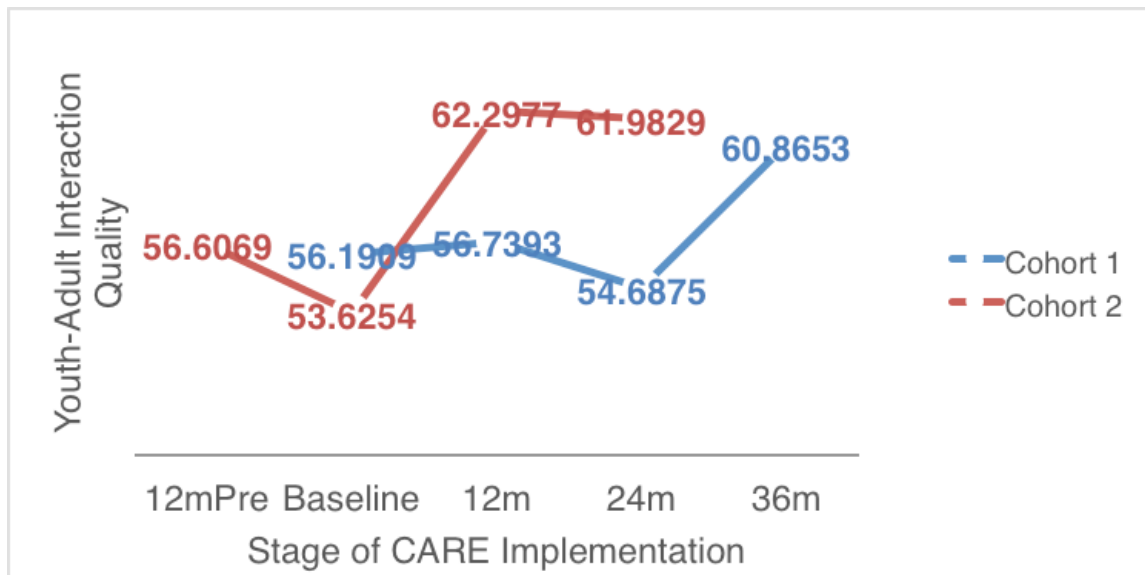
Figure 2 illustrates adjusted estimates for the frequency of incidents per resident over the entire four-year study period. The figure shows the three outcomes for which results were consistent across Cohorts 1 and 2. To adjust for overall agency differences in the frequency of incidents, estimates were centered at each agency mean. More information about incident rates and trends across different time periods and cohorts is provided in the full report (see Izzo et al., 2016).

Study 2: Effect of CARE on Youth-Adult Relationship Quality

To test whether agency participation in CARE was associated with improvements in youth-adult

relationship quality, we used a Cohort Sequential design in which 7 agencies were assigned to begin CARE immediately (Cohort 1), and 9 agencies waited about 12 months before beginning CARE implementation (Cohort 2). We examined whether youth outcome variables in Cohort 1 showed greater improvement during the first year of CARE compared to the change observed in Cohort 2 during the same year (i.e., before CARE). Beyond the first year, we assessed program impact by testing whether the duration of CARE implementation predicted improvements in youth outcomes, pooled across all 13 agencies. Both sets of analyses incorporated linear mixed model analysis of variance to account for clustering within agency and within residential unit (e.g., cottage).

Study 2 Results. As shown in Figure 3, for the first cohort, relationship quality scores showed a slight, non-significant improvement during the initial year of CARE implementation, and a significant increase during the second year, which was sustained into the third year. For Cohort 2 (wait-list) agencies, attachment scores did not change during the year before CARE implementation, but increased significantly during the first year of implementation. Scores for the second cohort remained high in the second and third years of implementation.



Discussion

Despite the stressful conditions that lead to out-of-home placement, group care can represent a tremendous opportunity to provide youth with corrective or therapeutic experiences that promote social and emotional development (Manashko, 2009). The current paper summarizes recent results (previously reported elsewhere) on the effects of CARE, a setting-level intervention to improve residential care quality.

The first study indicated that agencies' participation in CARE led to significant declines for three important types of behavioral incidents (aggression toward staff, property destruction and run-aways).

The second study indicated significant effects of CARE implementation on youth-adult relationship quality. Youth reports from the first cohort of agencies indicated gradual, significant improvement in relationship quality during the three year implementation period. Significant improvement was also observed in the second cohort of agencies during the implementation period, but not in the year preceding implementation (the baseline period).

There have been few rigorous studies of organizational or setting-level interventions in the field of residential youth care (James, 2014). Our use of rigorous quasi-experimental designs involving implementation across multiple sites provides strong evidence to conclude that the observed improvements in agencies were related to their participation in CARE.

Our research demonstrates that by focusing only at the staff and organization-levels CARE significantly reduced the prevalence of behavioral incidents that create a distressing, non-therapeutic environment in the daily lives of residents. Given that incidents such as these can escalate into physical restraint or, in extreme cases result in injury or death (Day, 2002; Nunno, Holden, & Tollar, 2006), the potential benefits of reducing behavioral incidents can be profound. The program's impact can also be considered in terms of the reduction in "ambient stress" created by such incidents, which adds to the cumulative developmental risk they already face (Evans, 2003; Gorman-Smith & Tolan, 1998).

Given the commensurate improvements in youth-adult relationships quality observed in Study 2, it is plausible to attribute the reductions in behavioral incident rates partly to improved youth-adult relationships and greater flexibility, such that staff were more likely to respond to transgressions in ways that avoided power struggles, hostility, or alienation. This explanation is also consistent with results from Anglin's qualitative study (Holden, Anglin, Nunno, & Izzo, 2014) based on interviews and observations across seven experienced CARE agencies that were actively working to sustain CARE after four years of implementation. Staff reported greater understanding of trauma's effect on youth behavior, leading to fewer confrontations and power struggles, less fear, and a more peaceful environment in the homes.

The current study illustrates a contextual approach that reduces dangerous incidents and improves youth-adult relationships by providing a common set of principles that change how agency leaders and staff think, how they interact with residents, and with each other. Results suggest that by adopting the CARE framework agencies can build key capacities within their workforce that improve their ability to serve the best interests of children.

Acknowledgements

This research was supported in part by a multi-year grant from The Duke Endowment, Charlotte,

References

- Anglin, J. P. (2002). *Pain, normality, and the struggle for congruence: Reinterpreting residential care for children and youth*. Binghamton, NY: Haworth Press.
- Burns, B.J., Phillips, S.D., Wagner, H.R., Barth, R.P., Kolko, D.J., Campbell, Y. & Landsverk, J. (2004). Mental Health Need and Access to Mental Health Services by Youths Involved With Child Welfare: A National Survey. *Journal of the American Academy of Child & Adolescent Psychiatry* 43(8), 960-970.
- Day, D. M. (2002). Examining the therapeutic utility of restraints and seclusion with children and youth. *American Journal of Orthopsychiatry*, 72, 266-278.
- Evans, G.W. (2003). A multimethodological analysis of cumulative risk and allostatic load among rural children. *Developmental Psychology*, 39, 924-933.
- Glisson, C. & Hemmelgarn, A. (1998). The effects of organizational climate and interorganizational coordination on the quality and outcomes of children's service systems. *Child Abuse and Neglect*, 22, 401-421.

- Glisson, C., Hemmelgarn, A., Green, P., & Williams, N.J. (2013). Randomized trial of the availability, Responsiveness and Continuity (ARC) organizational intervention for improving youth outcomes in community mental health programs. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52(5), 493-501.
- Gorman-Smith, D. & Tolan, P. (1998). The role of exposure to community violence and developmental problems among inner-city youth. *Development and Psychopathology*, 10, 101-116.
- Holden, M.J. (2009). *Children and residential experiences: Creating conditions for change*. Arlington, Va: Child Welfare League of America.
- Holden, M. J., Anglin, J. P., Nunno, M. A., & Izzo, C. V. (2014). Engaging the total therapeutic residential care program in a process of quality improvement: Learning from the CARE model In J. K. Whittaker, J. Fernandez Del Valle, & L. Holmes (Eds.), *Therapeutic residential care with children and youth: Identifying promising pathways to evidence-based international practice*. Philadelphia, PA: Jessica Kingsley.
- Holden, M.J., & the TCI Instructors of the Residential Child Care Project. (2009). *Therapeutic crisis intervention, reference guide (6th ed.)* Ithaca, NY: Cornell University.
- James, S. (2014). Evidence-based practices in therapeutic residential care. In J. K. Whittaker, J. Fernandez Del Valle, & L. Holmes (Eds.), *Therapeutic residential care with children and youth: Identifying promising pathways to evidence-based international practice (142-155)*. Philadelphia, PA: Jessica Kingsley.
- Izzo, C.V., Smith, E.G., Holden, M.J., Norton-Barker, C.I. & Nunno, M.A. (2016). *Preventing Behavioral Incidents in Residential Child Care: Efficacy of a Setting-Based Program Model*. *Prevention Science*.
- Lee, B.R., & Barth, R.P. (2011). Defining group care programs: An index of reporting standards. *Child Youth Care Forum*, 40, 253–266.
- Manashko, S., Besser, A. & Priel, B. (2009). Maltreated children’s representations of mother and an additional caregiver: A longitudinal study. *Journal of Personality*, 77(2), 561-599.
- Nunno, M., Holden, M., & Leidy, B. (2003). Evaluating and monitoring the impact of a crisis intervention system on a residential child care facility. *Children and Youth Services Review*, 25, 295-315.
- Nunno, M., Holden, M., & Tollar, A. (2006). Learning from tragedy: A survey of child and adolescent restraint fatalities. *Child Abuse & Neglect*, 30, 1333-1342.
- Ryan, J. P., & Testa, M. F. (2005). Child maltreatment and juvenile delinquency: Investigating the role of placement and placement instability. *Children and Youth Services Review*, 27, 227–249.
- Shadish, W.R., Cook, T.D., & Campbell, D.T. (2002). *Experimental and quasi-experimental designs for generalized causal inference*. Boston, MA: Houghton-Mifflin.
- Sunseri, P. A. (2004). Preliminary Outcomes on the Use of Dialectical Behavior Therapy to Reduce Hospitalization Among Adolescents in Residential Care. *Residential Treatment for Children & Youth*, 21(4).

Zinn, A., DeCoursey, J., Goerge, R., & Courtney, M. (2006). A study of placement stability in Illinois. Chicago: Chapin Hall Center for Children. Retrieved from <http://www.chapinhall.org/research/report/study-placement-stability-illinois>



Canadian Accreditation Council

Leading Experts in the Accreditation of Human & Health Service Organizations
Standards | Support | Success

Recognition . . .

CAC has been recognized both nationally and internationally, allowing us to provide you with excellent services.

National Recognition:

CAC has been recognized as an approved accrediting body for:

- Health Canada
- Alberta Health Services
- Alberta Child and Family Services

International Recognition:



CAC has been accredited by the International Society for Quality in Health Care, ISQua.

CAC Standards . . .

CAC provides accreditation services for Health and Human Service Organizations throughout Canada using the **2011 Edition of Child, Youth and Family Standards** and the **2011 Edition of Adult Standards**. These standards have been created with your needs in mind.

Every organization that undergoes accreditation through CAC is provided with extensive personal support, an on-site orientation, a pre-site evaluation of documentation, access to our Resource Centre (including sample policies), opportunities to network with similar organizations and electronic copies of the standards at not additional cost.

Your work helps other grow, develop and succeed. So does ours.

Arla Professional Building
300 10446 122 Street
Edmonton, AB T5N 1M3

Phone: 780.424.4498 Toll Free: 1-888-222-1248
Fax: 780.425.4828
www.cacohs.com



YOUR LEADERSHIP

CAN MAKE A DIFFERENCE

**PREPARE YOURSELF
WITH A MACEWAN DEGREE**

BACHELOR OF APPLIED HUMAN SERVICE ADMINISTRATION

MacEwan.ca/HSA

BACHELOR OF CHILD AND YOUTH CARE

MacEwan.ca/CYC