Creating Conditions for Change: The Evidence-Based CARE Program Model for Residential Settings

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The Gap
Our knowledge far exceeds our practice

Therapeutic Residential Care

Involves the planful use of a purposefully constructed multi-dimensional living environment designed to enhance or provide treatment, education, socialization, support and protection to children and youth with identified mental health or behavioural needs in partnership with their families and in collaboration with a full spectrum of community-based formal and informal helping resources.

—Whittaker, Holmes & del Valle (2016)

Purpose of Therapeutic Residential Care

▪ Creates “breathing room”
▪ Provides a safe place to learn new skills and practice
▪ Provides adults who act as teachers, coaches, and mentors to help develop and practice necessary life skills
▪ Helps children realize a more normal developmental trajectory

What Works

▪ Maintaining a positive organizational culture
▪ Providing strong leadership communicating a clear vision
▪ Building developmental relationships
▪ Committing to reflective practice at all levels of the organization
▪ Using data in decision-making
▪ Developing a competent and skilled workforce
▪ Creating a community of practice

Core Challenge for Agencies

Struggle for congruency throughout the agency in serving the best interests of the children
Why a Program Model

- Provides a conceptual framework and evidence informed theory of change that creates the conditions for change.
- Guides all staff members interactions and use of everyday events as they occur in the life space to teach interpersonal and pro-social skills.
- Improves children’s abilities to engage in treatment, education, and other interventions more effectively.

Developing the CARE Program Model

- 2005-2006 – literature review, survey of agencies, expert advisory group, developing measurement instruments, field testing components
- 2007-2009 – pilot model in 7-10 agencies, develop implementation model, refine measurement instruments
- 2010-11 – Anglin review of implementation process
- 2010-2016 – multi-site Duke study of 14 agencies to build evidence base for model
- 2015-17 – interrupted time series study – developing CARE fidelity criteria and instruments
- 2017 – CEBC Listing Level 3, High Relevance

The CARE principles are grounded in

- Theory
- Evidence-based practice
- International child care standards
- Practice wisdom

CARE Principles

- Family involved
- Relationship based
- Trauma informed
- Competence centered
- Ecologically oriented
- Developmentally focused

CARE Theory of Change

- Professional decisions
- Personal knowledge
- Practice knowledge
- Procedural knowledge
- Empirical knowledge

Drury-Hudson (1997)
Levels of the Organization

- External agencies
- Leadership and management
- Supervisors and clinical staff
- Direct caregivers
- Children and families

Implementation Strategies

- The agency is the locus of learning
- 3 year implementation agreement
- Quality assurance activities based on continued self-assessment
- Participation-centered management strategies
- Education, training and technical assistance
- Data informed decision-making

Phases of Implementation

- Preplanning
- Start Up Phase
- Initial Implementation
- Full Operation Phase
- Sustainability

Preplanning

- Recognition – why we need a model
- Exploration – what will meet our needs
- Decision – how do we choose
- Goal - what do we hope to gain from implementing CARE
- Preparation - how have we prepared the organization

Start Up Phase

- Collect baseline data
- Create CARE implementation team
- Conduct leadership retreat
- Create & communicate the vision
- Develop implementation plan
- Modify programs as needed
- Allocate sufficient resources
- Identify agency CARE educators

Initial Implementation Strategies

- Develop agency CARE educators
- Train all staff in CARE
- Supervisory support for coaching & hiring
- Provide technical assistance, observations, feedback
- Use adaptive leadership skills
- Use implementation group meetings to assess and plan for further implementation
- Collect, analyze and use data in decision-making
Full Operation Phase Tasks

- CARE principles integrated throughout organization – policies, procedures, practice
- Leaders and supervisors support & facilitate the new practices
- Staff are selected and promoted based on CARE criteria
- Implementation team meets regularly
- Data-informed decision-making is the norm
- Sustainability planning begins CARE integrated into CQI
- Reflective practice is the expectation

Sustainability Operation Phase Tasks

- Maintain fidelity to model while adapting to changing ecology
- Maintain data feedback system to monitor continued effectiveness and improve CARE integration
- New leadership developed (succession plan)

The CARE Program Model: The Evidence Base

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CARE is listed on the California Evidence-Based Clearinghouse for Child Welfare

- Scientific Rating of Promising Research Evidence
- High Child Welfare Relevance
- Two topic areas:
  - Higher levels of placement
  - Alternatives to long-term care

The Residential Child Care Project Research Team

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CARE Theory of Change

Organizational Culture and Climate

- Understanding of CARE practice principles
- Beliefs about children’s developmental needs

Individuals

- Fractions align with CARE principles
- Strengthen relationships, improve relational skills
- Adjust expectations to child’s developmental level
- Create opportunities for growth and self-efficacy
- Involve families in program and service planning
- Respond to children’s behavior and respond sensitively, non-punitively
- Engage in group and service planning
- Engage in biopsychosocial behavior and respond sensitively, non-punitively
- Engage in physical and social environments

Sustainability

- Support implementation – Assist with troubleshooting
- Facilitate reflection and learning – Provide data-based feedback

Strengthen relationships, improve relational skills

- Involve families in program and service planning
- Recognize trauma-based behavior and respond sensitively, non-punitively
- Enrich physical and social environment

Children

- Social and emotional learning
- Behavior regulation
- Well-being

Therapeutic relationship with staff
- Mastery, gratitude, and autonomy
- Inclusion and connectedness with family
- Resilience, safety, and voice, peaceful discipline

Opportunities for participation and social interaction
Aligning Data Collection with Theory

Waterford Time Series Studies

- **Info about Waterford**
  - Connecticut agency providing a diverse service array to help children and families
  - CARE implementation began in January 2009
  - Training saturation reached 18 months later in July 2010

- **Evaluation Design**
  - Data collected consistently as a standard part of internal agency processes
  - Three programs within the same agency
  - 12 years of data, 72 months prior and 72 months post

Fewer physical restraints for shelter

Fewer physical restraints for residential

Use of psychotropic meds decreased
Duke Multisite Evaluation

- 13 agencies across North Carolina
- Agency Characteristics
  - Two to six residential units per agency
  - 17 direct care and supervisory staff per agency, on average
  - Most direct care staff live in residence for 1-2 week shifts
- Youth
  - 27 children per agency, on average
  - Typical age range was 7-18 years old
  - Most referred by Dept of Social Services

Duke Behavioral Incidents Study

- 11 Agencies provided monthly totals of serious behavioral incidents from reports in their administrative data base
- Incidents were grouped into five categories:
  - Aggression Toward Staff
  - Aggression Toward Peers
  - Self Harm
  - Property Destruction
  - Running Away
- Agencies also provided monthly census, allowing us to compute rates

\[ \text{Incident Rate} = \frac{\text{Number of Incidents per month}}{\text{Average number of residents per month}} \]

Duke Youth and Staff Survey Studies

- Quasi-Experimental Waitlist Research Design
  - Yearly Surveys
  - Staff: knowledge, beliefs, current practice, and reactions to CARE implementation
  - Youth: quality of relationships with staff

Youth Perception of Relationship Quality

- Children/youth ages 8-21 participated in annual surveys
- Youth were asked to think about all direct care staff
- Youth rated 33 items
- Youth rated how often staff interacted well with them in various situations
  - Times when you are feeling upset
  - Times when staff did not like your behavior
  - Times when the unit has group activities
  - How staff deal with your family or loved ones
Young people reported improved relationships with staff

Staff Surveys

Knowledge
- Surveys occurred at Baseline, Post-training, and then annually
- Staff completed thirteen multiple choice questions about key CARE concepts and topics (e.g. Environmental factors that affect behavior, trauma)

Beliefs
- Baseline and annual surveys included sections on beliefs
- Staff read eight scenarios describing situations commonly encountered in residential care settings and rated their agreement with several responses or statements about each situation. Examples include
  - New resident who refused to eat with other children
  - Girl screaming about conflict she’s having with another resident
  - Young girl seeking attention/clinging to staff
  - Resident not following rules or expectations
  - Planned recreational activities
  - Child demanding more autonomy

Staff “Looking Back” Study

Research Questions
- To what extent did staff perceive that their own beliefs and practice had changed?
- What kinds of changes did staff say they experienced? Were those changes aligned with CARE principles and Theory of Change?

The Data
- Each year, staff answered open-ended questions about changes they experienced and observed as a result of CARE.
- We analyzed data from 304 records:
  - Only direct care or supervisory staff
  - Working at agency at least 1 year
  - Only included most recent survey

Most staff reported perceiving changes as a result of CARE implementation

Staff knowledge and CARE-like beliefs increase

Changes In Staff Beliefs
- Ongoing Consultation & Support
  - Train personnel
  - Expose to CARE concepts and principles
  - Recommend practice changes
  - Model and role play strategies and skills

Changes In Staff Practices
- Supervision & Agency Norms
  - Underlying Causes (24%)
    - Behavior/Distress
      - More thoughtful, intentional (18%)
      - Impact of Trauma (17%)
      - Less Behavioral Mindset (10%)
      - “Focus on the cause … not the behavior itself”
    - Uniqueness of child; Need to Individualize (22%)
      - “It helps me look at each child individually within the group”
      - “More intentional and aware in my interactions”
    - “… helped me be more conscious of trauma in my boys lives”
  - Impact of Trauma (17%)
    - “I learned that you don’t always have to give consequences”

Youth Experience
- Social and emotional well-being

Relationship Building (29%)
- “Yes, lots of talking, getting to know the resident, building relationships”
- “I can let go of the fact that they may not be doing what I asked of them”

Less Punishment (16%)
- “Less knee-jerk to consequences”
- “List of consequences is gone”

Skills & Success (10%)
- “Building opportunities … For clients to foster growth”

Autonomy Support (6%)
- “Offering choices & opppty to talk about situations they disagree with”

CARE-related Dialog and Reflection (29%)
- Common Language / Congruence (11%)
  - “We speak the same language which keeps direction more focused”
- Normality / Calmness (6%)
  - “… supervisors interact with staff using principles as example of how we should interact with children”
  - “The atmosphere in the cottage is more relaxed”

Residential Child Care Project at Cornell University
How Do We Know CARE Works?

- The evidence for CARE
  - Staff
  - Children
- Strength of the evidence

CARE Evidence: Staff

1: Increase in CARE-like beliefs
2: Increase in CARE knowledge
3: Increase in CARE-like practices
4: Increase in CARE-like supervision

CARE Evidence: Youth

1: Decrease in physical restraints
2: Decrease in psychotropic medication
3: Decrease in behavioral incidents
4: More positive relationships with staff

Strength of the evidence

- Strong research designs
  - Many years of data
  - Multiple agencies
  - Statistical controls
- Consistency in patterns of change
  - Multiple Studies
  - Qualitative and quantitative data
- Alignment
  - Theory of change & outcomes
  - Congruence across children, staff, organizations