The Building Bridges Initiative: Residential and Community-Based Providers, Families, and Youth Coming Together to Improve Outcomes

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The Building Bridges Initiative (BBI) provides a framework for achieving positive outcomes for youth and families served in residential and community programs. Founded on core principles, an emerging evidence base, and acknowledged best practices, the BBI emphasizes collaboration and coordination between providers, families, youth, advocates, and policymakers to achieve its aims. Examples are presented of successful state, community, and provider practice changes, and available tools and resources to support all constituencies in achieving positive outcomes.

Youth who are in residential care don't need to be there for so long. They get too comfortable. . . . That's all they know (Youth).[1]

The approach should think about voice and choice and be driven by family concerns, not a clinical or pathological view of what family can or can't do. Residential treatment should be used as a tool to get the best information about what the needs are and develop a strategy to address those needs (Family Member).

Research findings consistently indicate that positive outcomes for children with behavioral and emotional challenges and their families result from operationalizing values consistent with community-based system of care approaches in all settings (Burns, Goldman, Faw, & Burchard, 1999; Burns, Hoagwood, & Mrazek, 1999; M. Courtney, personal communication, August 17, 2007; Courtney, Terao, & Bost, 2004; Davis & Koyanagi, 2005; Jivanjee, Koroloff, & Davis, 2008; Leichtman, Leichtman, Cornsweet, & Neese, 2001; Partnership for Youth Transition Initiative, 2007; Woolsey & Katz-Leavy, 2008). Residential-specific research shows improved outcomes with shorter lengths of stay, increased family involvement, and stability and support in the postresidential environment (Walters & Petr, 2008). Accordingly, a research-based synthesis is emerging, suggesting that when residential and community providers integrate or "bridge" values and practices, improved outcomes can be demonstrated.

Historically, there has been some tension (and not much structured, solution-focused discussion) between community- and

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residential-based service providers around issues such as length of stay, the lack of collaboration during referral/intake and discharge transitions, treatment approaches, and fundamental philosophical issues. The absence of a framework for addressing these issues productively is compounded by the limited research base around this topic. Evidence for the effectiveness of residential treatment has been mixed, longitudinal follow-up has been rare (Walter & Petr, 2008), and research into the effects of community services, particularly those organized in systems of care, has shown promising, but not yet definitive, outcomes (Farmer, Mustillo, Burns, & Holden, 2008).

The Building Bridges Initiative (BBI) represents a growing national effort to promote a dialogue and provide a framework to address the identified issues through advancing consistent principles and coordinated practices across the full array of residential and community-based services. The BBI calls for restructuring relationships among all entities serving families and youth by means of more effective collaboration and operationalization of core principles. This call has resonated throughout the field as states, counties, national associations, residential, and community program practitioners, families, and youth have formally or informally used BBI products and principles to improve practices.

This article describes the evolution of the BBI from articulating principles to successfully implementing changes in policies and practices in communities nationwide.

The BBI: A Collaborative Vision for Residential and Community Programs

> *Focus on interventions that can transition home. If a program doesn't include family and doesn't consider culture and can't be transitioned home, then it is probably not going to work (Family Member).*

1 The comments from family members and youth throughout this article come from a series of focus groups held in summer 2007 by the Building Bridges Youth and Family Partnerships Workgroup and Training Programs in New York City on Youth-Guided Care.

Background

The BBI was launched in 2005 to strengthen partnerships between community- and residential-based treatment and service providers, policymakers, advocates, families, and youth, and to generate an effective approach for all service providers. With support from the Substance Abuse and Mental Health Administration's Center for Mental Health Services, the BBI was designed to improve integration and collaboration and promote innovation and best practices that would lead to positive outcomes for children and families served in residential and community programs.

The first BBI (2006) summit was inspired by compelling youth and family input, and it resulted in a drafted and signed BBI joint resolution (BBIJR) stipulating common underlying principles for the BBI (see Table 1). The BBIJR has since been endorsed by 24 national organizations and 20 agencies, including CWLA. A second BBI summit, held in 2007, focused on the operationalization of BBI principles and practices to "take the changes to scale" nationally. This summit resulted in the development of a strategic plan specifying ongoing short-term activities, long-range plans, and a number of products and deliverables.

The BBI offers a framework which capitalizes on both research and best practices to achieve impressive results (e.g., successful partnerships; reduced lengths of stay; increased youth and family engagement, skills, and satisfaction).

Table 1
Building Bridge Initiative Joint Resolution Principles (BBI, 2006)

These fundamental values and principles operationalize the Building Bridges Initiative vision of a more efficient service delivery system, more effective and appropriate individualized services to children, youth and families, and improved outcomes.

- Youth guided
- Family driven
- Culturally and linguistically competent
- Comprehensive, integrated, and flexible
- Individualized and strength based
- Collaborative and coordinated
- Research based
- Evidence and practice informed
- Sustained positive outcomes

BBI Leadership

The BBI's work has coalesced around the intensive efforts of a Steering Committee composed of national leaders responsible for coordinating BBI activities and executive-level decision making. Three active workgroups are charged with addressing and implementing various components of the BBI: outcomes, social marketing, and youth/family partnerships. Other ad hoc workgroups are formed as needed to address emerging needs that promulgate successfully implementing BBI (i.e., fiscal and policy barriers and successful strategies). All groups include youth and family members as co-chairs or members. Additionally, there are two overarching advisory groups comprised entirely of youth and family members. Significant and intricate efforts toward transformational change, grounded in BBI principles and practice, are being made by providers, families, youth, communities, and states throughout the nation.

Measuring and Implementing BBI Efforts to Transform Service Delivery

> *Nobody asks me about my dreams. They ask me about my behaviors (Youth).*

> *The outcome should be: success at home, in school, and in the community, so the goal should be to lead to that—with success defined by the family and the young person (Family Member).*

The BBI Performance Guidelines and Indicators Matrix

The BBI *Performance Guidelines and Indicators Matrix* (BBI, 2008), composed of an extensive set of performance guidelines and indicators, provides residential and community programs, families, youth, and policymakers with a framework for achieving positive outcomes according to the vision and principles articulated within the BBIJR. The matrix (see Table 2) was purposely developed to (1) assess an organization's conformance with BBIJR principles and (2) address an array of treatment supports and services that are ideally available in local communities, and that draw on established linkages between community and residential programs.

Table 2
Building Bridges Initiative Matrix: Components and Emphasis (BBI, 2008)

Cross-cutting performance guidelines are to be assessed through surveys or interviews with youth, families, and providers across the following domains, applicable throughout the entire episode of care:

- CFT
- Family-driven/youth-guided care
- Collaboration and communication among system partners
- Cultural and linguistic competency
- Quality assurance and quality improvement

Phase-specific performance guidelines and performance indicators are specified in measurable terms across three phases of care:

- Referral/entry
- During/within residential
- Transition and postresidential

Child well-being outcome measures that have demonstrable evidential support in the literature offer one means of evaluating the impact of implementation of Building Bridges principles in care settings for both proximal (e.g., readmission rates) and global (e.g., substance use, employment) outcomes.

The development of the matrix was informed by research and the experiences of youth, families, and providers; it is grounded in the recognition that all elements of the service system must engage in transformation (from preventive to intensive services, all systems, and both formal and informal supports). The matrix is further predicated on the assumptions that (1) other regulatory processes monitor basic standards in residential programs and community services; (2) in-depth self-assessment instruments exist to address specific principles such as cultural competency and wraparound fidelity; and (3) both the residential and the community service sectors share the responsibility of successfully implementing these practices and performance guidelines.

The concept of a child and family team (CFT; used generically in the BBI to encompass wraparound, family group decision making, and other similar approaches) is embedded throughout the matrix as a fundamental element integral to successfully implementing BBI

principles and practices. The CFT process is defined as "a group of people—chosen with the family and connected to them through natural, community, and formal support relationships—who develop and implement the family's plan, address unmet needs, and work toward the family's vision" (Miles, Bruns, Osher, Walker, & National Wraparound Initiative Advisory Group, 2006, p. 9). The literature supports this approach as a means to move practice into alignment with the concepts of family-driven and youth-guided care and to improve outcomes in a variety of domains (Bruns, Rast, Walker, Peterson, & Bosworth, 2006; Burns, Hoagwood, et al., 1999; Carney & Buttell, 2003; Clark, Lee, Prange, & McDonald, 1996; Evans, Armstrong, & Kuppinger, 1996; Evans, Armstrong, Kuppinger, Huz, & McNulty, 1998; VanDenBerg, Bruns, & Burchard, 2003).

CFTs support the development of an individualized plan of care and promote purposefulness and accountability for all team members (e.g., youth, families, residential, and community-based providers). Although not a BBI–specific process, the CFT is central to implementing all of the cross-cutting BBI principles, including the adoption of youth-guided and family-driven practices, which accounts for its prominence in the matrix.

Organizational Self-Assessment Tool

The matrix provided a framework for the development of a self-assessment tool (SAT). The SAT is a detailed self-administration instrument with items corresponding to the performance indicators in the matrix that can be used to propel a self-assessment process within organizations (i.e., residential and community providers). Accordingly, organizations, youth, and families can use the SAT to assess the degree to which BBI practices and principles are being implemented within the organization. This self-assessment process is designed to create a dialogue within organizations and their varied constituencies to foster quality improvement based on BBI principles and practices.

The SAT has been refined through an extensive pilot-testing process. Together, the matrix and the SAT afford users the opportunity to identify areas for growth.

Building the Bridges: Agencies and Communities' Innovative Efforts to Apply BBI Principles and Practices

The [staff] were very welcoming and treatment wasn't pushed on me when I first got here. They find out what you want to work on, what you need, and give you choices (Youth).

Rather than calling it discharge, we should call it transition . . . and do it as a transition. Make sure services are available, communicate with community services providers at intake and discharge, [have] residential providers help with discharge and stay involved (Family Member).

Throughout the nation, hundreds of residential and community provider staff are operationalizing BBI principles and implementing BBI tools to achieve the mission articulated by the BBIJR. Both residential and community program staff report having "transformed" their agencies based on BBIJR principles, from hiring executive-level family advocates, to implementing the CFT approach, to hiring youth mentors (Katana & Lieberman, 2009). Several states, counties, and residential programs have specifically used the BBI as a springboard to promote best practices and better outcomes for youth and families, as demonstrated by the following examples.

County and State Efforts in New York

Implementing CFTs and ensuring integration of community-based services and supports throughout the residential intervention has been a focus for several counties in New York. Westchester and Monroe Counties have developed BBI to promote increased alignment between residential and community-based services and reduce residential lengths of stay.

Monroe County

In a Monroe pilot project, youth enrolled in a community-based wraparound program, the Youth and Family Partnership, and were concurrently enrolled in a residential program for stabilization and

brief focused intervention. The community-based CFT was expanded to incorporate representatives from residential providers, which allowed all providers (residential and community based) to work in partnership with the child/youth and family to address specific needs. During concurrent enrollment, services were delivered within the milieu and campus-based residential setting and in the community. The pilot supported residential and community-based providers in developing new ways to work together, and also highlighted the need for the CFT to be explicit in identifying the specific need and purpose of the residential intervention.

Westchester County

Westchester has embarked on an effort that has included use of lower levels of care, reductions in lengths of stay, and building relationships between residential and community-based providers. The primary focus has been to actively engage residential providers to become partners in the system of care and participate in CFTs. Historically, residential programs had not been included in system of care development and when children with complex, intense needs were placed into a residential program, they became isolated and services were disjointed.

Despite the reality that the children in both of these counties would eventually be returned to the community, strong connections between the residential provider and the community-based service system were not generally established or maintained while they were in the out-of-home setting. Through using CFTs, both residential- and community-based providers are now included in the planning process and services that meet specific identified needs have been expanded or developed. The CFT remains active throughout the residential episode and after discharge. This practice has helped to ensure continued community integration throughout the residential stay and successful transition back to community. They are further supported in their efforts by an ongoing statewide BBI that has been incorporated into the New York State Children's Plan, a unified effort to address the social and emotional needs of children and families, which was jointly submitted by nine commissioners

of child-serving agencies in New York (New York State Office of Mental Health, n.d.).

Damar Services in Indiana

This program provides yet another example of integration of CFT into residential services. Damar Services extends residential treatment into more natural homelike environments; young people move from the residential setting into a transitional home within their communities and then to their own homes. Staff from the residential setting move with the young person into the transitional home while concurrent CFT work is provided by the Dawn Project, a care coordination program administered by Choices, Inc. (Blau & Caldwell, 2008).

A study conducted on 100 youth enrolled in the Dawn Project included statistically significant improvements on the child and adolescent functional assessment scale (Hodges, 1994) and an increased number of young people living in less restrictive settings 12 months following enrollment (Anderson, Wright, Kooreman, Mohr, & Russell, 2003). More recently, Damar Services has begun a new pilot focusing on integrating family and community treatment in residential services, which has demonstrated a significant reduction in length of stay (4 months for pilot enrollees vs. 11 months for the control group) and also reflected cost savings of over $1 million in one year (J. Dalton, personal communication, February 20, 2009).

Youth-Guided and Family-Driven Care: Requisite Principles to Successfully Implement BBI

> *It is not a role for residential treatment to be parents. Residential treatment providers can get in a mindframe that [they] are parents. There is a family and they should be present and involved from day one (Family Member).*

> *My biggest thing is the youth being involved in their planning. [If not,] later down the line when it's time for them to leave care, they are not properly prepared for adulthood (Youth).*

Youth-guided and family-driven care are fundamental precepts in systems of care and are fully integrated within the BBI. At every point in the evolution of the BBI, these two principles have been operationalized concretely to ensure that families and youth drive conceptualization, integration, and implementation. The Youth and Family Partnership Workgroup oversees every aspect of the BBI, including articulating policies and reviewing products.

Fully implementing family-driven and youth-guided care has many angles. On an individual level, it assures that each youth's and family's voice is heard and respected in all phases of services. Youth-guided practice is individualized and positive and proactive in supporting each youth's success through strategies identified by the youth and family. Similarly, family-driven practice is engendered by practices that reflect a deep-seated belief that families are central to children's well-being, and that respectful and meaningful family engagement is critical to achieving positive outcomes.

The BBI Family and Youth Advisory Groups have drawn heavily on the experience of their respective family and youth members to author a series of brief family- and youth-friendly guides, which provide families and youth with an understanding of best practices in residential programs and promote overall empowerment in guiding their care. The BBI *Youth Tip Sheets* and *Family Tip Sheets* offer information on best practices related to some common elements (e.g., education, communication, linkages with home, restraint, and seclusion), as well as youth- and family-specific issues—each through a distinct youth or family lens. These tip sheets are available for residential, peer support, and advocacy programs to share with families and youth.

As a part of the BBI, several residential and community providers have taken significant action to acknowledge the expertise and centrality of families and youth. The following are a few illustrations of what this shift can look like.

Family Peer Advocates

Enhancing the roles families play within organizations is another means to transforming service delivery. Roles for family members

include serving as peer partners; supporting family members (e.g., during the team process); serving as resources for all employees of the organization; and becoming resource developers, system advocates, and evaluators. Family members can play an integral role in the hiring and training processes.

In California, Hathaway-Sycamores Child and Family Services acted on its commitment to family-driven care by hiring more than 20 family partners to support family engagement efforts for youth entering the residential program. These individuals have also enhanced the agency's overall attention to incorporating family voice into all agency activities and forums, at both practice and policymaking levels.

Pennsylvania has defined and incorporated family-driven care indicators into expectations for residential providers, including the indicators in state contracting requirements through managed care. Using contractual provisions specific to family-driven care can provide the impetus for organizations to thoroughly review and improve practices. Organizations nationwide, including EMQ Families First in California, Southern Oregon Adolescent Study and Treatment Center in Oregon, Uta Halee-Cooper Village in Nebraska, and Villa Maria in Maryland, have also implemented similar family-driven care practices.

Youth-Guided Care

Youth-guided care is a critical component of the BBI. The Jewish Child Care Association (JCCA) of New York has advanced several efforts to promote youth ownership of their care. An initial purposive discussion about the role of youth in designing their own interventions included discussion about the perceived loss of control felt by staff. Focused attention like this is critical to buy-in and facilitating practice change, as many human service professionals have been schooled in their expert role and find relinquishing decision-making authority to their clients challenging.

JCCA also established youth councils across their residential and foster care services to ensure that youth voice was integrated into all decisions. By convening annual youth and staff strategic planning retreats and by involving youth in hiring and training activities,

JCCA was able to promote partnerships between youth and staff that have resulted in more innovative programming and a higher degree of investment by youth and staff.

Family Search and Engagement

Many residential providers have shared that they serve youth with no viable family. New, very successful models for finding and establishing long-term connections to family members for these youth have been developed. The research demonstrates how important this is to sustained outcomes. One model, the family search and engagement approach (Brimmer, Boisvert, Campbell, Koenig, Rose, & Stone-Smith, 2001; Catholic Community Services of Western Washington, 2009), explores current and potential connections in a child's life to identify long-term family resources. Outcomes from using this approach have been impressive. For example, between 2007 and 2008, at Hathaway-Sycamores Child and Family Services (2008), "114 new family members were discovered; of these, 50 family members became engaged with youth and 21 new permanent family connections were achieved."

What You Can Do to Build Bridges: Products and Recommendations

Families, youth, providers, advocates, and policymakers are encouraged to sign onto the BBIJR and make a personal and professional commitment to the philosophical predicates and principles governing the BBI and guiding professional practices throughout the nation. The BBI provides resources for all constituencies seeking to implement BBI principles and practices (see Table 3 for documents, available at www.buildingbridges4youth.org).

Other steps policymakers and providers can take to implement BBI principles and practices are:

- Review program practices against the BBI principles, matrix, and SAT and make corresponding changes and improvements. For example, families are welcome in the program at all times (24 hours a day, seven days a week), and youth spending time

Table 3
Building Bridge Initiative Products

- Building Bridges Joint Resolution: Statement of shared values and principles
- Performance guidelines and indicators matrix: Provides residential and community programs with a framework for achieving positive outcomes
- BBI self-assessment tool: Tool for community and residential programs to assess the degree of implementation of BBI principles
- Family tip sheets: Developed by family members to empower others with easy-to-understand expectations for best practices in residential programs
- Youth tip sheets: Developed by young people to empower and inform youth and equip them with information before entering a residential program

with family members at home and going back and forth regularly between the residential program and their home and community is regarded as a core program component (rather than as a visit or privilege contingent on behavior).

- Implement practices consistent with youth-guided, family-driven, and trauma-informed care including (1) training youth and families to lead or colead treatment team meetings; (2) providing youth and family members with support to serve as cotrainers in staff orientation and as members of hiring teams for new staff and to have meaningful input into staff and program evaluation; and (3) implementing empowering individualized approaches that can be easily transferred to home and community, moving away from standardized approaches that are not supported in the research or easily transferable to home (Hart, 1992; Mohr, Martin, Olson, Pumariega, & Branca, 2009; Mohr & Pumariega, 2004).
- Create welcoming and family-friendly environments and develop or expand educational/learning opportunities for family members, at times and community locations convenient for the families.
- Support youth and families during their time in residential programs to continue to participate in community-based programs (i.e., recreation) and support services in their home

communities, thereby facilitating timely and smooth transitions home.

- Include or hire youth and family members to serve on agency committees and workgroups and in permanent positions dedicated to engaging and supporting the youth and families served.
- Implement best-practice and evidence-based models that correspond to a range of positive outcomes, adhering to fidelity whenever possible. These include CFT process, wraparound, family group decisionmaking, and family search and engagement (Burchard, Bruns, & Burchard, 2002; Burford & Hudson, 2001; Catholic Community Services of Western Washington, 2009; Catholic Community Services of Western Washington & EMQ Children and Family Services, 2008; Walker & Bruns, 2006).
- Promote dialogues among families, youth, advocates, residential, community, local, and state constituencies about BBI and implement policies, practices, and financing mechanisms consistent with the BBIJR.

Advocates and policymakers are recognizing that coordination and collaboration across residential- and community-based settings is essential to improving outcomes. The BBI paradigm promotes shared responsibility and shared commitment, regardless of service needs or treatment setting, and ensures that best practices are promoted and outcomes are improved for youth and families served in residential and community programs.

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