Advances in Applied Sociology
2013. Vol.3, No.2, 102-105
Published Online June 2013 in SciRes (http://www.scirp.org/journal/aasoci)

Scientific Research
http://dx.doi.org/10.4236/aasoci.2013.32013

Rural Adolescent Residential Treatment Facilities as Centers of Clinical Support and Excellence*

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Received January 31st, 2013; revised March 2nd, 2013; accepted March 10th, 2013

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In rural western states (e.g., Wyoming, Idaho, Montana, Utah) that are large geographically and small in population, it is unrealistic to expect to have comprehensive mental health and substance abuse professional support in most rural communities. One viable idea is for mature and distinguished treatment facilities in those geographic areas to expand their delivery system.

Keywords: Rural; Residential Treatment; Adolescents; Clinical Support; Best practices

Introduction

This article's concepts, recommendations, and suggestions are directly tied to the recently released Guidelines for Cultural Competence in Rural Child Welfare (2009). The problems encountered at Cathedral Home for Children (CHC) (a residential adolescent treatment facility in Wyoming) are typical of many rural treatment services. For example, youth represents a high poverty rate, elevated parental substance abuse, and poor access to mental health and substance abuse services (CWLA, 2009).

CHC is a rural residential treatment center in the Rocky Mountain Region of the United States. The agency is a nationally recognized Joint Commission accredited residential treatment facility that offers specialized educational, psychological, and therapeutic services for adolescents. Youth are referred to this facility for one or more of the following reasons: 1) noncompliance in school, 2) history of criminal activity, or 3) having been a referral to Child Protective Services. The youth at CHC range in age from 12 - 17, with approximately 57% male and 43% female. Typically 75% - 85% of the participants identify their ethnicity as European American, with 10% - 15% Hispanic, and 5% - 10% American Indian/Alaska Native. 40% to 50% of the youth comes from families below the poverty line, and about 55% report parental substance abuse/addiction.

This article includes ways in which unique rural challenges are faced, particularly related to what happens to youth aging out if residential care back to rural settings and innovations for support and professional education for rural child welfare staff. CHC uses service delivery methods that have been tested and are evidence-informed, but adapted for rural settings. How are those methods are different from urban ones will be described and a rural model for a "Center of Clinical Support and Excellence" will be explained.

*Note: copies of pertinent national refereed journal articles and summaries (CHC Research Briefs) are available on CHC's web-site (www.cathedralhome.org)

What Happens to Youth Aging out of Residential Care in Rural Areas?

Rural settings present a unique challenge in terms of availability, accessibility and acceptability of services. CHC is no exception to these challenges. For example transportation in Wyoming is extremely challenging with some in-state rural youth coming from communities over 10 hours away by car. Accessibility of coordinated services for family members are also quite challenging, with many youth coming from communities of less than 1000 in population and larger communities perhaps a 5 hours car drive away. Stigma in Wyoming communities is also quite high, and consistent with CWLA findings for rural communities (2009), such stigma is tied to the perception that confidentiality for accessing services cannot be maintained.

For youth aging out and returning to a rural setting, such services are severely limited compared to what metropolitan areas offer. As youth age out of the child welfare system, unprotected by the social welfare system they once relied on for their survival, they must quickly adapt to becoming independent adults. For example, leaving a recovery environment like CHC, which provides both instrumental support (medical, dental, food, clothing, shelter) and psychosocial support (academic, recreational, mental health) to a rural community that offers few if any of those services is quite daunting. As challenging as transitioning may be for youth returning to metropolitan settings, going from the full slate of services to very few if any is typically not their reality. Therefore youth returning to rural settings need to be prepared to creatively access transitional services.

CHC has recently become more intentional in educating youth about their transitional needs for rural environments. Inspired in part by a recent article, Preparing Youth for the Transition into Adulthood: A Process Description that specifically addresses rural issues (Ringle, Ingram, & Newman, 2007), CHC is adapting a process in which youth returning to rural

settings complete an educational experience over a 6-month period immediately before their transition through a series of structured real-life activities and lessons. These activities include a workbook that provides real life rural situations, and possible solutions for accessing services in such setting (e.g., skyping, phone conferencing, on-line resources). The "class" incorporates independent living curriculum (e.g., job searching is a rural area, budgeting, time management, dealing with rural transportation costs), an alumni program (that matches youth with others in the community or within 50 - 100 miles), and aftercare services provided by CHC that includes a once per month face-to-face visit and regular phone calls from a CHC professional that extend their current services and 'trouble-shoots' with them related to specific problems and accessible services.

Results from the Ringle, et al., (2007) 5-year follow-up study indicates that those who completed this process reported more positive functional outcomes than those who did not. This process and effective after-**care** services helped these young adults maintain the gains established during treatment. As adapted at CHC, key interventions include online, pre-placement and post care arrangements; all recommended by CWLA'a Guidelines for Cultural Competence in Rural Child Welfare (2009).

Similarly, CHC transitional services have drawn from another rural based article, called Transitioning Behaviorally Disordered Young Adults from a Structured Residential Treatment Center into Independent Living in a Small, **Rural** Community, by Conrad (1991), The program consisted of three levels, each offering more independence, while providing support, guidance, and direction to the transitioning youth. Each level encourages greater personal, economic, and emotional responsibility and independence related to returning to his/her rural setting. For example, each youth works with child welfare professionals to think through the challenges of their particular rural setting in terms of relapse potential and the recovery environment, then incorporate these insights into the transitional plan. CHC has built in this level system to help youth determine the level of independence often needed in rural environments to be successful and how crucial planning and decision-making are keys in environments where more formal social supports are not present. CHC accents the value of developing informal supports during this process, encouraging participation in church groups, community clubs, volunteerism, and on-line connections as part of the planning.

Rural Child Welfare Staff Development-Challenges and Recommendations

CHC specifically has been recently aggressively addressing the CWLA Rural Cultural Competency of 1f:

"*Rural child welfare staff and administration should receive additional support to develop child welfare competencies and professional education*".

Child welfare staff and administration in rural settings are faced with many professional challenges (Smith, 2003). Professionals tend to lag in training for diagnosing, intervening and treating mental illness, while the need for such competence grows (DeLeon, 2000). For example, "in the United States, at least 15 million rural residents struggle with significant substance dependence, mental illness, and medical-psychiatric co morbid conditions" (Roberts, Battaglia, & Epstein, 1999: p. 497). Compared to urban and suburban settings, rural settings consistently report higher incidences of abusive drinking, suicides, mood and anxiety disorders, and chronic illness (Roberts et al., 1999).

There are many benefits to child welfare staff and administration in a rural setting, such as lifestyle (clear skies, slower pace, clean air, and close social networks), lower overhead and cost of living, greater autonomy, more collegial relationships, varied tasks and functions, and community identity and recognition. However, rural child welfare staff and administration often face role overload, heightened stress and burnout, relationship/role/boundary challenges, professional isolation, economic issues (e.g., scarcity of resources), lack of social/cultural opportunities, and lack of privacy (DeLeon, 2000). This reality in rural areas is often exacerbated by "a constant search for balance between professional and ethical issues" as helping professionals in rural areas are very identifiable (Smith, 2003).

These assertions are supported by a major study, in which Weigel and Brown (1999) discovered that the chief challenges indicated by rural child welfare staff and administration were limited resources, few staff members with large caseloads, varied presenting client issues, geographic isolation, limited supervision and consultation options, and high employee turnover. Weigel and Brown concluded that there are potential problems with stigma and local credibility due to the "close-knit" nature of rural communities, [where] child welfare success or failures are often visible and public. In addition, Brownlee (1996) noted that the rural child welfare professional who participates actively in community life will eventually encounter this particular dilemma, often further contributing to a sense of isolation. The solution to such challenges is additional support.

Rural Residential Treatment Facilities as Centers of Clinical Support and Excellence

In rural states (e.g., Wyoming, Idaho, Montana, Utah), it is unrealistic to expect to have comprehensive mental health and substance abuse professional support in rural communities. One viable idea is for mature and distinguished treatment facilities in those areas to expand their delivery system. For example, a rural Residential Treatment Center (RTC) can act as a regional hub- providing outreach to rural regional needs. This idea is related directly to several CWLA Guidelines for Rural Cultural Competence (2001), especially Standard 5: "Child welfare professionals in rural communities should deliver services in a culturally competent manner, be knowledgeable about services, and be able to marshal existing resources to best serve their clients". One such example of this model is now being implemented by Cathedral Home for Children (CHC), located in Laramie, Wyoming. Located in the least populated state in the US, CHC provides regional outreach in crisis center cervices, group home options, prevention, aftercare, tutoring, psychological testing, and coordinate home health care for a large geographic region (120 square mile radius), and to rural communities that would not be able to access these services any other way. In that RTCs have trained professional and resources, this "center of excellence" model for rural communities is highly feasible, and will help in transitioning CHC youth to independent living.

The Alliance for the Safe Therapeutic and Appropriate use of

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Residential Treatment (**ASTART**) (co-sponsored by the Department of Child and Family Studies of the University of South Florida and the Bazelon Center for Mental Health) recently developed a Parent's Checklist—called "Warnings for Parents Considering a Residential Placement for their Child and Adolescent"—that was supported and co-sponsored by a number of agencies (e.g., Child Welfare League of America, American Psychological Association). A RTC can take such recommendation and develop an *outreach function* to turn perceived weaknesses into strengths, and improve communicate to parents and other key informants, as outlined below.

The **Table 1** lists points on ASTART's Parent Checklist with information about how and RTC can address each point per the "***Center of Clinical Support and Excellence***" Model.

Funding for this kind of initiative can come from cultivating partnerships with the state, private grants and counties. This model could also effectively address another CWLA rural competence standard (1g).

1g. *Supports for increasing competence and professional education should include: compensation for tuition*, *compensation*, *for travel time to courses*, *development and access to online education*, *and reduction in workload to accommodate the special needs of rural employees accessing education.*

For example, the RTC as a ***Center of Clinical Support and Excellence*** can provide the services needed in rural settings; as described below:

1) *Consultation* and *clinical supervision* are essential to prevent isolation and redundancy of ineffective techniques. The rural child welfare professional can create an interdisciplinary consultation group by collaborating with teachers, clergy, police officers, judges, and paraprofessionals all of which bring specific expertise and appropriate care to child welfare (Smith, 2003).

2) *Continuing education* is another large component to keep-

Table 1.
Cross Referencing ASTART, RTC, CWLA Guidelines.

Astart	RTC as a *center of clinical support and excellence*	Examples of CWLA Corresponding Guideline(s) for Cultural Competence in Rural Child Welfare
State-licensed and accredited with regard to all 3 aspects of the program: the 1) educational, 2) mental/behavioral health and 3) residential components?	1) Educational-Communicate the fully accredited nature of the on-site school by the state and emphasize the employment of certified teachers; provide *consultation and training* services to outlining rural school districts on how to deal with "alternative education" youth. 2) Mental/Behavioral Health-Communicate the rigorous accreditation adherence (e.g., Joint Commission for Accreditation of Health Organizations) for behavioral health care; *offer expertise* to outlying rural school districts and MH clinicians re: accreditation, certification; *explore options* of covering such facilities with current agency accreditation. 3) Residential Components-emphasize the close adherence to the Child Welfare League of America's (CWLA) Standards of Excellence for Residential Services (see CWLA's web-site), including but not limited to elements of rural service and treatment (e.g., cultural competence, child-centered, family-focused services), organization and administration of residential services (e.g., administrative structure that includes continuous quality improvement processes), and service environment (e.g., sound building design and recreational space and equipment). Promote sponsoring *regional training* seminars accenting the delivery of such principles in aftercare, prevention, et al. (e.g., bi-monthly)	5b. Collaboration is essential in rural communities 5c. Rural administrative oversight and support for creating services is essential 1. Child welfare professionals should work with rural populations in accordance with the unique need of rural cultures
Respect the wisdom and expertise of parents and youth?	Accent the deep commitment to involving parents and to a family-centered philosophy per JCAHO and CWLA recommendations; provide *training* to rural regional providers, deliver regional direct *services* to parents and youth	3b. Allow rural children to remain connected to their home and social network
Provide quality therapeutic interventions?	RTC can provide *training and direct services* based on high standard therapeutic interventions including individualized treatment plans for each youth and family, with detailed explanations for best practice therapies and interventions to help that particular youth and family adapted to rural settings. For example, an RTC can *train other rural agencies* to provide monthly reviews to update treatment interventions, and testing is re-administered every 6 months to assess progress.	7b. Maximize community resources
Admit youth with psychiatric diagnoses but then do not provide appropriate medical treatment?	In keeping with best practice, an RTC can make their *consulting psychiatrist as well as other medical personnel* (*nurse*) available and on call to monitor, update, and adjust medications to the best results for the rural youth served.	2b. Understand the important juncture of time and distance in rural practice

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ing abreast of current child welfare issues and trends and this is limited in the rural setting. Again, collaboration with other professionals can bring this needed information. Professionals such as attorneys, medical professionals, domestic violence educators, and invited child welfare professionals from other locations can provide continuing education and advancement (Smith, 2003).

3) *Applying for grants*, *conducting fundraisers*, and promotion can help rural agencies provide low cost services and will be much less affected by state and federal funding cuts (Smith, 2003). For example, several universities are looking to collaborate with rural mental health agencies for special federal grants set aside for rural communities. A phone call or email to the social work and/or counseling training programs at the state universities could be a fruitful start.

4) The *training of new child welfare professionals* should include a rural emphasis; and those bachelor level social work students, masters level social work and counseling students, and doctoral level psychology stude6ns planning on working in the rural setting should do at least part of their practicum and internship hours in a rural setting (Smith, 2003).

5) *Conducting community outreach programs* provides an opportunity to introduce yourself to members of the community, explain your services, and decrease the stigma of child welfare work, plus enhanced training in computer information systems can relieve record keeping and administrative time. Promoting online training courses and continuing education classes can reduce isolation and increase professional development (Smith, 2003).

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