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Creating and Maintaining Family Partnerships in Residential Treatment Programs: Shared Decisions, Full Participation, Mutual Responsibility

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Introduction

There is an accumulation of evidence that family involvement and family-centered practice make a difference in outcomes of residential treatment. Whittaker (2012) reviews a number of North American sources dating back to the 1960's, all supporting the critical role of active family and community involvement in enhancing positive outcomes. Geurts et al (2012), with more emphasis on the European literature on residential treatment, similarly identify a range of papers connecting family involvement to better conditions in care and better overall outcomes. This emerging consensus in the scholarly literature is also supported by the values of current national policy formulations, including Systems of Care principles (Stroul and Friedman 1986), the Building Bridges Initiative (www.buildingbridges4youth.org) and the Federation of Families for Children's Mental Health (www.ffcmh.org) , among others. (See also Walter and Petr, 2008 and American Association of Children's Residential Centers 2006; 2009). Whittaker sums up this present context for practice in residential treatment succinctly:

> "The weight of the empirical historical evidence as well as the experience of countless residential treatment programs is that a robust and encompassing set of avenues for family engagement constitutes, if not a **sufficient** element in achieving positive outcomes, clearly a **necessary** one: both to meet the goals of permanency and treatment efficacy previously cited and to fulfill the widely shared value commitments to include parents as full partners in the treatment process. (Whittaker, 2012)"

Yet what does all this mean in terms of real-life practice? The present chapter draws on our own collective range of experience with therapeutic residential care (including the perspectives of chief executive management, senior clinical leadership, and experienced parent leadership), as well as on concepts from the Building Bridges Initiative to describe how the implementation of full value family partnerships requires changes in structure and culture within the residential program from pre -admission to discharge planning and aftercare, and also requires new skills for professional helpers and family members alike. Again based on our experience, we will highlight the critical role of the Professional Parent Liaison (PPL) in maintaining effective team work between staff and empowered family members in the high tension environment of the residential treatment center. First, we submit a working definition of family-centered practice specific to therapeutic residential settings for children and youth.

Working Definition

Family-centered practice in therapeutic residential care is characterized by a set of pervasive institutional structures and a range of services, supports and professional practices designed to:

- **Preserve and, whenever possible, strengthen connections between the young person in care and his or her extended family, most broadly defined;**

- **Facilitate and actively support full participation of family members in the daily life of the program; and**

- **Promote shared responsibility for outcomes, shared decision making, and active partnership between family members and all helpers.**

We believe that therapeutic residential care programs effectively re-engineered with this practice blueprint can be powerful environments for families to begin the work of connecting and reconnecting, especially where other factors related to safety and stability have made residential treatment the best option. Of course, implementation of the above blueprint requires significant, even transformational changes in practice.

Self-assessment as a Platform for Agencies Developing Family-Centered Approaches

Implementation of a family-centered approach means first assessing the organization's readiness for and commitment to family-centered practice. The Residential Child Care Project (CARE) at Cornell University (Holden et. al. 2010) developed a Family Involvement Survey in 2011 that was based on earlier work by Walker's Trieschman Center Carolinas Project (2000), supported by the philanthropy of the Duke Endowment. The survey was designed for organizations looking at how to engage families in key aspects of the organization's functions and to support meaningful family involvement in their child's treatment during their residential stay. The CARE survey is

completed by agency staff and asks questions about: how the organizational culture and policies address family engagement practices (e.g. written policies and procedures, mission statement, staff orientation, professional development, roles for family members in corporate governance); the admissions process starting from referral to entry into the residential program; the care of the child and communications with the family once the child is admitted to the program; and how the transition planning and discharge is managed (http://rccp.cornell.edu/caremainpage.html). Although not designed to be used with families or funders it could be adapted for that purpose in order to provide a critical outsider's perspective on how well the agency is meeting their family-centered goals.

A second approach to getting ready for family-centered practice was developed through the Building Bridges Initiative (BBI). BBI is a national initiative in the U.S. - federally sponsored by the Substance Abuse and Mental Health Services Administration - working to identify and promote practice and policy that will create strong and closely coordinated partnerships and collaborations between families, youth, community and residentially-based treatment and service providers, advocates and policy makers to ensure that comprehensive mental health services and supports are available to improve the lives of young people and their families. The BBI outcomes workgroup developed a number of products to support the development and enhancement of family-centered approaches to residential interventions. Similar to the CARE approach, BBI focused on assessment first, developing a self-assessment tool that has versions for youth and families as well as staff and advocates (Spanish language versions are available as well). (BBI, 2010) The BBI tools look at the issue of family-centered practice at a much more granular level than the CARE survey. Both approaches bring a "family-centered lens" to examine policies, programs and practices from pre-admission through the residential stay and including the

discharge and aftercare experience. In addition to the self-assessment tool, BBI developed a performance guidelines and indicators matrix for agencies to use as a quality improvement tool measuring adherence to family-centered practice (BBI, 2009).

Family-centered practices in Residential Treatment Centers

We have found the BBI matrix of performance guidelines most useful in mapping out practices in support of real, measurable family partnerships. Examples of preadmission practice guidelines include asking families, residential staff and referral sources whether: marketing materials accurately reflect the program's outcomes data; policies and utilization rates of emergency safety procedures like restraint or seclusion are available to families; admission and intake procedures are developed for the family and child's convenience and comfort; there is outreach to community providers who have worked with the family in order to capitalize on their insights and treatment relationships with the family; the agency uses current and alumni parents and children as "Ambassadors" welcoming new families and children to the Residential Treatment Center (RTC); transportation and other barriers are addressed and plans developed to ensure frequent opportunities by parents and siblings to spend time with the child at the program, home and community.

Preadmission family-centered practices in particular look at possible barriers to full partnership between families and residential providers at the outset of the treatment. Written and oral communication emphasizes that the work will not be successful without the family being fully engaged in the treatment. The family gets to identify who its members are and what roles they will play in the treatment. If a child is referred to a residential provider with no identified family

members the residential provider immediately works with the referring agency and guardian (typically the state child welfare department) to identify someone who can serve in this role. This may involve intensive efforts to identify biological family members not previously involved; identifying a foster family where the child can go after discharge; or minimally, identifying a visiting resource for the child even if this person will not ultimately be a full-time caregiver (see: Louisell, 2007 for a well-articulated description of family finding in the U.S.). The treatment plan should always be focused on "what is it going to take" to return this child to their home and community safely, and with enduring family ties even if the child and family cannot live together full time.

Family-centered practices emphasize the full participation of the family throughout the child's residential stay. Guidelines looking at the experience of the child and family during the residential stay include: parents not being treated as guests and granted 24/7 access to their child and visits are not conditional based on the child's progress within the program; parents get to decide the members of their child and family team; there are clear protocols developed with the family about how often and what information will be communicated about their child; community partners who have worked with the family are encouraged to remain involved during the residential stay and are seen as partners in the family's care; decisions are reached by consensus with the family seen as the expert regarding their child and professionals are used as consultants to the family and child; shared formulation of the problem and shared vision of the solution; only interventions that can be meaningfully replicated in the home and community are utilized; goals are youth/family driven, strength-based, oriented to the least restrictive options and used to regularly measure progress; assessment and utilization of natural supports is emphasized; cultural and linguistic preferences of

the family are respected and attended to; youth are encouraged to be home and in the community as much as they are able to do so safely.

Discharge planning from a family-centered perspective starts at admission by asking "what will it take for the child to be safe and behaviorally stable in the home and community?" All interventions are then oriented around this goal. Discharges should not be made arbitrarily based on a certain date or duration of treatment but based on achieving the treatment goals. Frequent progress meetings should occur to ensure the child is reunited with their family and returned to the community as quickly as is safely possible. Delays in progress should be a cause for alarm by the treatment team and reconsideration of the formulation of the problem and reconsideration of the treatment plan may be needed if a child's stay becomes prolonged or progress towards goals is not achieved. Management of risks associated with treatment decisions becomes shared between the family and residential provider, community resources, funding agency and any other systems involved in the child and family's care. This allows for the development of mutual responsibility in the context of shared decision-making. Aftercare guidelines include: detailing what services and supports will be provided to the family post-discharge; developing an aftercare crisis plan with specificity and practicality; lining up post-discharge respite care options; and determining what services the residential care agency can provide the family in the community either directly or in collaboration with community-based agencies.

BBI encourages the use of data to track outcomes important to families in order to understand whether the residential agency has made a lasting impact that is sustainable including: educational outcomes; medication rates; response to behavioral and clinical interventions as established by the child's individual treatment plan; use of emergency behavioral interventions including restraint

and seclusion; length of stay; and discharge outcomes. Systemic measures would also look at the role of parents in hiring, training and evaluating residential staff and whether family members have a meaningful role on agency governance structures.

Implementation of family-centered practice means constructing a system that prioritizes the needs of the family over those of the residential provider. It means the system is designed and built from the ground up with a singular focus on what families want and need to treat their child. This is not to say that there won't be times when there are competing needs or values creating conflict between families and providers. How these conflicts are addressed and resolved is the true measure of family-centered practice.

Beyond Advocacy: The Essential Role of the Professional Parent Liaison

With the increased policy emphasis on family-centered care, a new role, sometimes called Parent Partner or Family Advocate, has emerged in the behavioral health workforce in the U.S. (Purdy 2010; Obrochta, et.al 2011). For purposes of this chapter we refer to this position as Professional Parent Liaison (PPL), in part to emphasize the role as a resource to families and to staff members working to fully include families in the helping process. Optimally, the PPL draws from his/her lived experience, in combination with formal training and/or professional education, to guide, empower and plan with families navigating service systems. Family partnership staff, whatever their formal title, have been part of the out-patient and community mental health landscape for many years and continue to gain recognition as influential members of care teams. In the residential treatment program, we think the role of the PPL is particularly critical.

Ideally, the residential program's PPL is a member of the agency's senior management team. This gives families a prominent, visible presence from top to bottom in the program, sending the clear message that commitment to family partnership is one of the highest priorities of the organization. In turn, the therapeutic residential setting gains a resident expert whose "insider" views and background are represented in decision-making at every level. By strategically sharing their own experiences, the PPL at a senior level is positioned to challenge myths and assumptions about families parenting children with severe emotional disturbance; to help both staff and family members be heard rather than misunderstood; and to push care teams to plan helping strategies from a real life, strengths-based approach.

The PPL also plays a key role in maintaining the culture of full family partnership over time. Once a new practice paradigm is in place it has to be sustainable, and the truth is that managing a changing culture of professional practice, with family members as true, active partners, is not so easy. Real partnerships with families of young people placed in residential treatment require that everyone involved be respectful, honest, and trusting in the highest of high stress contexts. Thorny issues can arise as partnerships evolve and cultures change:

- Communication between direct care workers, clinical staff, family members and youth in care can get complicated at the least. Roles and responsibility lines are sometimes blurred or miss-communicated.
- Families and direct care staff may be hesitant to be open and honest with each other, or may lack the skills to manage conflict if it arises. Staff turn over may effect relationships and progress.

- Stress and trauma may adversely affect teamwork, especially when there are perceived power differentials. Families are worn out from looking for help and may appear resistant.
- Families may be invited, but they may not feel welcome or supported to fully participate in the program.

In all of these situations, the PPL can play an essential role in helping all sides of the partnership work together. Functionally, the PPL goes far beyond advocate to serve as resource, mediator, consensus builder, coach and innovator for families but equally so for residential treatment staff. The PPL represents the family perspective - most especially the diversity of families and family perspectives - throughout the organization, from employee hiring, orientation, and training to case consultation, and participation in treatment and risk management meetings, program and policy conversations, proposing new programs and transition planning services. The PPL must be ready to balance multiple roles at all phases of treatment - admission, during stay, transition, and after care.

The Role of the Professional Parent Liaison in the Admission Phase:

Completing the admissions process is an especially vulnerable time for family members in crisis who are coping with uncertainty about the present and future. It is an equally vulnerable time for the admissions staff pressured to complete contracts necessary to initiate service and reimbursement and keep beds filled. These competing stressors can inadvertently derail the optimum time to begin shaping a partnership with the family. Including the PPL in this process can help to ensure the relationship has a positive start or at best a "jump start" in collaboration. The PPL can instill credibility and confidence that the residential treatment program values their

expertise about their child. The PPL is a symbol of hope and relief. By having a true appreciation for and listening to the family's journey at the outset, they can begin to identify ways to help the whole care team understand each family's unique history and move forward together.

The Role of the Professional Parent Liaison during the Residential Treatment Stay

As noted above, on-going shared decisions and mutual responsibility for the care plan are attainable throughout placement when organizational culture supports engaging families as full partners. Keys to success include being able to develop a partnership with a family free of power differentials and respectful of cultural diversity, an ability to reach consensus on goals, roles and responsibilities, and sharing knowledge of practices and resources that work in the real world. The PPL can be an important facilitator of all of these activities.

A stay in residential treatment is just that, a defined period of time during which a child and family will stabilize, learn new skills and the child will return home as soon as possible. RTC's should seize natural opportunities to shift from doing things for parents (enabling) to having parents continue expected child rearing responsibilities (empowering). For example, parents could be asked to schedule hair cuts, choose after school activities and/or manage their child's medical care. These situations allow for maintaining community connections, continuity of care and easier transitions at discharge. As a matter of course family members have not been included in daily routines in residential treatment programs, but family driven care practices prescribe welcoming family members into this culture. Allowing family members unfettered access to the milieu, however, can be particularly stressful for both staff and family members. Embracing this

opportunity, however, is one of the most ideal ways for both parents and temporary caretakers to learn from each other. The PPL can facilitate by guiding and modeling for both partners.

For staff members, most of whom are recent college graduates, with little to no parenting experience having family members around can be intimidating. Workers may be fearful they may be judged or criticized for doing something wrong. Inevitably the answer to the question "who is in charge" (staff or parent) may become unclear. Interestingly, family members also experience a similar range of concerns. The PPL can be a tremendous resource here. Having both an established relationship with family members and familiarity with the residential treatment program staff and routines allows the PPL to pose recommendations and coach staff and family members through stressful situations in the moment.

The Role of the Professional Parent Liaison in transition planning and aftercare

At transition we know a lot about the child's behavior. Harder to judge is the parent's readiness to have their child at home. The PPL, having travelled this anxious road is in a position to understand and allay a parent's fears while assisting staff in developing a plan that continues to move forward while acknowledging the legitimacy of family member worries. This may include, but not be limited to, visiting school programs with family; mediating staff and family priorities; suggesting staggered transitions to home, (weekends first, once mastered adding a day at a time until home full time); negotiating staff support for visits to home and community; and helping to craft crisis safety plans. Encouraging parents to practice self-care and make room for their own social interests as crucial parts of the discharge plan is also a helping function uniquely suited to the PPL.

The PPL can be helpful in designing and overseeing discharge surveys and tracking a family's progress at home. By remaining in touch with families, the PPL is able to develop an informal network of parents and offer updates to staff. Parents can become referrals for current families looking for information on services or schools. For staff, hearing that a child and family they worked with is doing well offers a tremendous sense of pride. Also, potential exists for the PPL to recruit and train family members to stay connected to former helpers as volunteer mentors and trainers to new families.

Questions for Future Research

As noted above, it seems clear that extant research over many years supports the finding that active family participation in therapeutic residential settings is connected to better outcomes. We also have lots of ideas - with lots of variance - about how this full participation should look in practice settings. Our colleague John Lyons at the University of Ottawa describes successful family partnership as re-making the residential treatment program to be "fully permeable" to families - empowering them as team members, but going beyond shared decision making to actively support family participation in the day-to-day life of the program (John Lyons, personal communication, 2012). This seems to us exactly right from the point of view of the residential center as a potentially powerful environment for connecting and reconnecting families, but it also raises many interesting questions for further exploration:

- Just how powerful are the ecological effects of frequent family participation in the life space?

- Should we think in terms of a bottom-line minimum of family contact with youngsters in care (including by phone, internet, and face-to-face), or is this best left to individual care planning?
- What are the implications for communication and information technology here, including privacy issues?
- Is frequency of family participation in the residential milieu an "active ingredient" of effective practice in and of itself?
- If family members are in more frequent direct contact with care staff, does this change communication patterns for the care team as a whole?
- Does more frequent family participation in the residential milieu change the behavior of the young people in care?
- Finally, do presumed positive effects related to frequent, direct family participation in the residential milieu enhance the impact of evidence-based family therapy interventions on offer to families in the program?

Exploring these questions and learning what we can from whatever answers we generate seems to us to be very promising for transformative future research and model building.

There are, of course, other potentially researchable questions raised by the practice realities of implementing full partnerships with families in therapeutic residential settings. In brief, some of the questions we think most suggestive for more practice research are:

- How do family centered teams, with parents as full partners, make decisions in real life? Our values tell us that fully shared decision making is best, but what does "shared" look

like in practice? Do staff and family members always have the tools they need to work together in the high stress context of residential treatment? What is the best way to empower staff and family members to be good team decision makers, especially when there is disagreement or conflict? As noted above, the Professional Parent Liaison may have a significant role to play here, helping struggling care teams as a mediator and coach. In our experience, most family-centered care teams work pretty well, but some don't. We need to learn more here.

- How do family-centered care teams make decisions about risk, especially perceived risks associated with the young person in care spending increasing amounts of time at home? Differing risk assessments between family and staff team members can create some difficult situations, with anxious family members feeling that their voices are not being heard, and program staff mistaking anxiety and trauma for lack of commitment to the young person in care. This can bring the whole care plan to a halt. We need to find more and better ways for family-centered teams to reach consensus about risks, as well as about what real supports will need to be in place for families to feel safe as the care plan moves toward discharge.

- Also noted above, there are many versions of what we have defined as professional parent liaison in use throughout the system of care as a whole. Now would be a good time for a comprehensive review of the varied roles and essential functions of parent liaisons as they are utilized specifically in therapeutic residential settings.

- Finally, what is best practice in therapeutic residential settings when families opt not to participate as active partners, even when programs make concrete, honest attempts to identify and eliminate barriers to participation? This seems to us to be a compelling question for practice and practice research. Do we know everything we need to know about who are the families we struggle to connect with? Does every family need to be an active partner at the same level? What are the rock bottom minimum ways we need to support families to work with the care team?

Answers to these questions and others like them will be very important as those of us in the field continue efforts to transform uninformed, ineffective program models of therapeutic residential care into powerful environments for family connection and support. As the present volume attests, we have come a long way here, but we still have lots to learn.

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