Embracing Family-Driven Care

Beth Caldwell, MS, Sherri Hammack, BS, JoeAnne Hust, Anne Kuppinger, M.Ed., Lisa Lambert, Bette Levy, MA, Ed.M., CTRS & JuRon McMillan, MBA

"Children go into residential programs as family members and when they are there, they remain part of their family too. Families have incredible knowledge and resources to offer and parents have enormous expertise to draw on. Yet, sometimes parents are welcomed, sometimes ignored, sometimes disrespected. Often, all three attitudes can be found in a single program."

Parent who asked to remain anonymous

Embracing Family-Driven Care (FDC)

Introduction

Every residential and hospital program strives to achieve long-term positive outcomes for children and families post discharge so that they can live together successfully in their homes and communities. The research is clear that to achieve sustained positive outcomes post-discharge, program practices must put a primary focus on engaging, supporting and partnering with family members (Walters & Petr, 2008; Blau, Caldwell & Lieberman, 2014).

Building Bridges Initiative (2007) found the strongest predictor of post-transition success from residential treatment, after education, was support from the family. Residential leaders who have tracked outcomes of children and families achieving sustained success in the community post-discharge found strategies that correlated to success involved engaging and working with families in their homes and communities (Dougherty, Strod, Fisher, Broderick, & Lieberman, 2014). They are taking bold action to improve their service and achieve better results. They are creating meaningful, positive outcomes by: promoting time spent at home and in the community (Huefner, Pick, Smith, Stevens, & Mason, 2015); minimizing lengths of stay; engaging families during and after residential

intervention (Casey Family Programs, 2016); and actively supporting staff, children and families in relevant, important ways (Blau, Caldwell & Lieberman, 2014; Levison-Johnson & Kohomban, 2014).

This chapter will provide information about a range of successful strategies to engage, support, and partner with family members, and operationalize the best practice value of family-driven care (FDC).

Every program can improve how they engage, involve, and support family members effectively. There are great resources and many 'early adopters'—hospital and residential leaders who have paved the way. Program leaders who have made the journey to putting a primary focus on family-driven care have had to address many challenges along the way. Despite these challenges, they have shared that it is one of the most important journeys that out-of-home programs can make!

An important first step for programs wanting to improve outcomes for children and families, is to develop a comprehensive action plan dedicated to becoming a family-driven organization.

All organizations are at different places on the path towards family-driven care. In some programs, staff members still believe that a residential or hospital program's job is to "fix" the child and protect the child from his/her family. Other organizations already have leaders committed to moving towards family-driven care but need to bring all their staff on-board. Some organizations have spent years perfecting their

family-driven care approaches. Wherever an organization is on their path, this chapter provides information that can support the journey.

This family-driven care section includes:

- Definitions and priority action areas
- Examples of family-driven care practices
- Next steps for organizations
- References
- Additional resources

In addition, there are recommended articles and resources on family-driven care in the *Additional Resources* chapter of the *Resource Guide*.

Definitions and priority action areas

According to the National Federation of Families for Children's Mental Health (2016), the definition of family-driven practice is as follows:

Family-driven means families have the primary role in decisions regarding their children as well as the policies and procedures governing the well-being of all children in their community, state, tribe, territory and nation.

This includes, but is not limited to:

- Identifying their strengths, challenges, desired outcomes/goals, and the steps needed to achieve those outcomes/goals;
- Designing, implementing, monitoring, and evaluating services, supports, programs, and systems;
- Choosing supports, services, and providers who are culturally and linguistically responsive and aware;
- Partnering in decision-making at all levels.

The National Federation of Families for Children's Mental Health (2016) also has identified Guiding Values to Achieve Family-Driven Practice.

Families and youth, providers, administrators, and policymakers accept and support willingly and enthusiastically shared decision-making and responsibility for outcomes, as evidenced by:

1. Families and children share and have access to accurate, understandable, and complete information necessary to set goals and to make informed decisions.
2. Families define their family composition and family decision-makers, whether biological, adoptive, foster, sibling, or surrogate family voice advocating on their behalf.
3. Families and family-run organizations engage in peer support to reduce isolation, achieve short-and long-term family goals, and strengthen family capacity and voice.

4. Families and family-run organizations provide direction for policy decisions that impact funding, supports, and services, including the right of families and children to have meaningful voice at the individual and policy level.
5. Providers, agencies, and systems take the initiative to change policy and practice from provider-driven to family-driven.
6. Providers, agencies, and systems embrace family-driven practice, by allocating staff, training, support and resources to adequately fund and sustain family-driven services for children, children and families, and the work of family and child run organizations.
7. Community attitude change efforts focus on removing barriers and eliminating bias and discrimination.
8. Communities value and celebrate the diverse cultures of children youth and families and work to eliminate disparities.
9. Communities recognize that culture is an ever-changing dynamic and are responsive to the cultural and linguistic needs of all children, youth and families.

Families exist in many different forms and each is different from the next, but all families can play a variety of roles in their child's life. In this chapter of the *Resource Guide*, the word family may refer to biological families, adoptive families, step-families, extended families, foster families, and/or other individuals or group of individuals who play a significant role in the life of the child. The implication of this broad, inclusive

definition of family is that providers should work with significant people in each child's life (with permission from the legal guardian) that may extend beyond those who have legal responsibility for the child.

Seven areas have been identified as priorities for organizations to assess and address as part of a family-driven care action or strategic improvement plan:

1. Hire and support family partners

A critical first action step for residential and hospital programs is to include a diverse group of family partners (sometimes referred to as 'advocates') as members of their staff. This includes hiring multiple family partners with various backgrounds, ethnicities, and cultures that represent the population of children and families who are being served. Family Partners are family members who have or are raising a child who has behavioral and/or emotional challenges and has been served in a residential and/or hospital program.

It is important for programs to include at least one senior family partner as part of their family partner team; the senior family partner can serve as a part of the executive team and provide supervision to other family partners. It is also important to have family partners (and family members) as part of every organizational workgroup committee/task force. Family partners should share offices with other staff spread throughout the organization, so they are fully integrated into all components of the organization.

Please refer to the section on *Successfully Working with Family Partners* for more information on this most important priority area for both successfully engaging families and operationalizing family-driven care into practice.

2. Ensure that every child realizes permanency with family they choose

It is a key responsibility of service providers to ensure that every child served has identified and involved family members who can serve as a permanent family. If a child does not have identified family members, then service providers should make finding and engaging permanent connections an urgent priority.

The work of finding family should be guided by the child's expressed wishes and in collaboration with existing family members and legal guardians. Full partnership with the appropriate Department of Children and Families is imperative in finding and supporting a permanent family for each child. Program executives must also engage in preliminary work with their state child welfare organization leaders and staff, judges, advocates, and other key partners to support collaborative family finding strategies. Walker, a Massachusetts-based organization, has developed a successful strategy for such partnerships.

There are several helpful tools for out-of-home programs to improve their knowledge about finding and engaging family members. One tool is the *Building Bridges Initiative Guide: Finding and Engaging Families for Youth Receiving Residential Services.*

The Family Preservation Team of Catholic Community Services of Western Washington State (CCS) developed the Family Search and Engagement (FSE) practice model:

> *"Family Search and Engagement (FSE) is a set of practices designed to locate, engage, connect, and support family resources for youth. A major goal of this practice is to move youth from a place where they don't hear "I love you" to a place where they can hear it and feel it every day. This comes from family, relatives, and others who love them. Frequently, though not always, these youths are involved in the child welfare system, have experienced multiple placements with non-relatives and have lost contact with their extended family members (Catholic Community Services of Western Washington, n.d.)."*

CCS has made their *Family Search and Engage Comprehensive Practice Guide* available at no charge.

Uplift Families First, a multi-service organization serving children and families in over 30 counties in California, shares the following about using the FSE model:

> *"The FSE program helps reconnect children with safe, healthy families and speed their recovery from emotional trauma. Using internet search technology, we are able to find biological family members for children in the system. Once we have identified family members, we work to reestablish relationships and explore ways to find a permanent family placement for the child."* (Uplift, 2017, para. 2).

The Seneca Family of Agencies in northern California utilizes Family Finding as their permanency practice model. The Family Finding model seeks to build or maintain the child's Lifetime Family Support network for all children who are disconnected or at risk of disconnection through placement outside of their home and community. The process identifies relatives and other supportive adults, estranged from or unknown to the child, especially those who are willing to become permanent connections for him/her.

Upon completion of the process, children have a range of commitments from adults who can provide permanency, sustainable relationships within a kinship system, and support in the transition to adulthood and beyond. Keeping safety at the forefront and using a family-driven process, families are empowered to formulate highly realistic and sustainable plans to meet the long-term needs of children.

Child outcomes may include increased reunification rates, improved well-being, placement stability, transition out of the child welfare system, decreased re-entry rates, and stronger sense of belonging for children.

The Seneca Family of Agencies has developed tools and resources to support this *Family Finding* model. They state that an 'effective relative search' employs a variety of effective and immediate techniques to first identify no fewer than 40 relatives or other meaningful connections for each child. The number 40 serves to create a large group of people from which to form a smaller tight-knit, unconditionally committed permanency team.

There are several different permanency practice models; Family Search and Engage and Family Finding, mentioned above, are just two examples of these permanency practice models. Some residential programs have developed and/or adapted their own permanency practice models, using available internet tools that search for families. There are also national organizations that program leaders can contact to learn more about implementing successful permanency practices. Two Massachusetts based programs doing this work are Walker and Plummer Youth Promise, the latter of which provides technical assistance nationally. It is essential that residential and hospital leaders fully embrace and prioritize developing program practices specific to ensuring permanent connections, and fully collaborate with their child welfare organization partners on this work.

3. Work with siblings

Many children served in hospitals and residential programs have siblings. It is important for programs to have expertise in working with and supporting the siblings of the child in out-of-home care. Family systems are complex, and all members are affected when a child experiences challenges that lead to out-of-home placement. Family members consistently rank 'working with siblings' as a priority for residential services.

For more information, refer to the following: Massachusetts Sibling Support Network; Building Bridges Initiative Tip Sheet: *Supporting Siblings When a Brother or Sister is Receiving Residential Interventions;* and *Supporting Siblings of Explosive Children.*

4. Create a broad community support network

The support network that is in place for children when they leave an out-of-home program correlates to how well the child is doing ten to fifteen years post discharge (Building Bridges Initiative, 2007). It is essential that every program develops a practice strategy for identifying, developing and implementing strong community support networks for every child and family served.

Additionally, focus on staff training and ongoing supervision in these and other critical areas support the full implementation of these different practices. Building a community support

network involves identifying a range of extended family members and friends who commit to becoming a part of a child's life for many years to come. Staff members work with children and families in defining their needs, as well as with identified network members to assess how to set up and support their defined needs.

Families and children should have the primary voice in developing the support plans they will need when the child returns home. Support plans often include formal services, such as in-home family support and/or job coaching, and supports, such as a church group and/or membership at the YMCA. Informal supports, such as spending time with extended family members, have also been found to be important. Successful plans include steps the child and/or family can take if one or more components of the home/community support plan are not working effectively. Identifying and successfully engaging a group of extended family and friends to participate in the home/community support plan has been found to increase the likelihood of each child and family experiencing long-term success.

5. Increase clinical skills in family systems and work effectively with families with unique challenges

Many hospital and residential programs have met with tremendous success at engaging and working with children with complex challenges. This same type of commitment to

engaging and working with families with complex challenges is needed for providers to successfully support the unique needs of a range of different families, each with individual strengths, challenges, cultural identities, and histories. Building clinical staff expertise and providing clinical supervision to ensure sophisticated skills in family systems and fidelity to best practice family engagement models is critical. Residential programs that have developed successful family engagement practices have sometimes replicated or utilized/borrowed strategies from evidence-based programs that include a family engagement practice strategy. These include Multi-systemic Therapy, Functional Family Therapy and Motivational Interviewing.

Family advocates across the country have shared that the primary responsibility of all staff members is to partner with families, not to 'do things' for families. To partner with families, the first step is engagement. Critical primary staff skills towards ensuring successful engagement include a strong focus on the basics, such as being respectful, empathetic, culturally sensitive, and demonstrating strong listening abilities.

6. Improve cultural and linguistic competence

Every family deserves to receive services and supports that consider their individual cultural, ethnic, and racial backgrounds, as well as their traditions. This is especially important, because racial disparities exist with children who are

placed in out-of-home care (Building Bridges Initiative Cultural and Linguistic Competence Workgroup, 2011).

It takes a great deal of time and effort to hire staff from all disciplines, especially executive leadership and clinical, who culturally and linguistically represent the families served. Many hospital and residential providers have staff, especially leadership and clinical staff, who are predominantly white, even when those they serve are predominantly of color. In some programs, staff may become frustrated with different family members, e.g., "She won't call," or "He won't follow through with anything we ask." When a program embraces cultural and linguistic competence, including hiring staff who culturally and linguistically represent the families served, family engagement and collaboration often improve. Hiring family partners who represent the ethnicities and languages of families served is a great beginning and helps to ensure family partners can communicate with the child or family, including those with hearing impairments.

7. Increase the amount of time staff spend working with families in their homes and home communities

Programs should facilitate daily communication between children and their families and help them spend as much time together as possible at home and in their home communities. For residential programs, the research points to the importance of reversing traditional program practices. Instead of staff time

focused primarily on child behaviors, treatment and recreational groups IN the program, staff time should shift to working with families in their homes, and supporting children in clinical, social, and recreational activities in their home communities. A primary locus of out-of-home care moves to providing a variety of direct-care and clinical services and supports in the home and community, with a strong focus on skill-building that is essential for success in these environments for both children and families. Real world settings are needed for addressing real world challenges and moving towards real world gains.

Examples of family-driven care practices

There are many administrative, clinical, and program practices listed throughout this chapter; they represent just some of the practices that operationalize the value of family-drive care. It is important to note that there may be practices listed in this section that an organization may not be ready to implement or practices that are not appropriate for a specific type of service. The practices in this section have been extracted from other documents written by experts and researchers in the field (see additional resources at the end of this chapter), feedback from family members and child and family partners/advocates, and experiences shared by residential and hospital leaders who have embraced family-driven care as a primary value and priority practice area.

1. Administrative FDC practices

(a) Executives/Leadership:

- Hire multiple diverse family partners and ensure that there is a lead family partner who serves on the organization's executive team. For example, Raquel Hatter, former CEO of a large residential program, went back to her organization after attending the first national Building Bridges Initiative Summit and implemented multiple improvements, including, but not limited to: Setting the tone that the primary focus of their organization's work should be on welcoming families as full partners; Hiring a senior executive focused on family; Rewriting all job descriptions to include comprehensive skill and practice expectations specific to family-driven care; and making supervisors accountable to ensuring staff everyday interactions and program practices were family-driven.
- Develop and implement a strategic action plan focused on the organization becoming family-driven, with family members included in the groups that are developing and implementing the plan. Using the *Building Bridges Initiative Self-Assessment Tool* can inform your strategic plan to strengthen family-driven practices.
- Ensure that family members are represented on Boards of Directors, external and internal advisory boards, and workgroups.

- Ensure that there are multiple opportunities for families—both individually and in small groups—to provide feedback on all organizational practices, and their own experiences. Do not rely solely on 'satisfaction surveys. Provide family members with multiple avenues to give their input on the work of the organization and their own experiences. For example, one executive leadership team member holds an exit conference with every family when their child transitions back home. Other leaders mandate that all executives have 'open door' policies for families. An increasing number of organizations include family member feedback on staff hiring decisions and on evaluations for all staff.
- Ensure that the organization's mission, vision and values include references/commitment to family-driven care/partnerships with families.
- Create a workgroup about successfully engaging families and/or family-driven care overall, and include children, families and advocates on this group.
- Review and update all policies to ensure the language is family-driven and represents best practices in family-driven care.
- Create a specific policy on family-driven care spelling out ways that the organization and staff share power, resources, authority, responsibility and control with family members on every level.

- Require and ensure that every leader in the organization is committed to family-driven care, and that leaders articulate and model these values and practices in their everyday interactions. For example, at Damar Services, Inc. in Indiana, direct care staff are assigned to families, not solely to units within the program.
- Dedicate resources to supporting families in a variety of ways. For example, coordinating and ensuring payment for children to spend time at home multiple times weekly, offering stipends for family members to serve on Boards or committees, offering culturally relevant foods at all program related events that family members attend both in the community and in the program, paying for baby-sitting services for younger children so family members can attend support groups and/or family treatment sessions in the community.
- Use data to inform practice and track outcomes such as readmission to a residential or hospital program up to two to three years post-discharge. For example, The Children's Village in New York State, tracks post-discharge data on the following measures: a) youth either graduated from high school or were still in school; b) youth were either in school or working at least part-time; c) youth maintained stable housing; and d) youth did not return to care/remained arrest-free.

Additionally, ensure that a robust quality improvement system is in place which includes a range of data measures correlated to engaging and successfully working with families, such as the number of weekly treatment and/or support contacts staff have with family members in their homes and communities, the number/percentage of children who spend time at home at least twice weekly, and the number of families successfully connected to community family support groups. Develop a dashboard of important family engagement measures; ensure there are 'red flag' alerts for critical dashboard items (e.g., child in program for three weeks and no work accomplished towards finding child a permanent home; child in program for three weeks and has not spent any time at home).

- Ensure multiple family members are represented on all organization workgroups and committees; some programs have implemented a policy that workgroup meetings will not occur if a family member/advocate is not present. Have family members/advocates actively participate in all external reviews, such as Joint Commission, Council on Accreditation (COA), and state organization licensing visits. Include families in a meaningful manner in at least the entrance and exit portions of these meetings.

(b) Staff training:

The CEO should be involved in orientation for new staff members and present on the program's ongoing commitment to best practice values, including family-driven care. In addition, training programs should be offered in the following areas:

- Understanding the importance of family-driven care.
- Reviewing organizational expectations for engaging, partnering, and respecting families. For example, in New York City, as part of a multi-year training initiative developed for the NYS Office of Mental Health, a philosophy of care was embraced by all community residential programs. Program leaders stated: Our commitment to each child and family is on-going; it does not allow for premature discharges; it strives to provide continuity; it supports transition planning from pre-admission; it promotes individualized and culturally competent service delivery and goals; it eliminates blame and supports the strengths of each child and family member; and it incorporates a "whatever it takes" and "never give up" attitude to providing help and support (Bette Levy, former NYC Field Coordinator, New York State Office of Mental Health, personal communication, January 23, 2012).
- Teaching skills and practices consistent with family-driven care, such as children calling extended family members several times a day and staff calling family members daily to share positive feedback—in addition to calls sharing concerns.

- Teaching sensitivity to issues involved in out-of-home placement for all family members, emphasizing that family members may have healing needs from their own personal histories in programs or hospitals. Family members may have had previous hurtful experiences with programs or hospitals that served one of their children where they did not feel respected or valued.
- Becoming knowledgeable and sensitive to the unique ethnic and cultural issues and traditions of children and families.
- Understanding and respecting confidentiality and informed consent.
- Understanding and respecting child and family rights.
- Ensuring that family partners serve as trainers and/or co-leaders for both new staff orientation and for regular in-services; involve families in the development of new training programs.
- Inviting family members to organization training programs and offering the training programs in normalized community locations at times convenient for family members.
- Ensuring families receive as much training as staff members.
- Having staff provide educational and support opportunities in the homes and communities of families.

- Having families participate in interviewing and hiring for the program, and for those who will work with them in their homes.

SAMPLE COMPETENCY: Embracing Family Members as Partners

The staff member:

1. Treats all family members with respect at all times (e.g., friendly; sincere; avoids use of acronyms; thoroughly explains all interventions and reasons for each; uses a variety of techniques to fully involve family members in discussions; prepares and supports family members/caregivers in participating and sharing their views in meetings).
2. Is able to easily identify multiple strengths of each family member.
3. Makes family members feel welcome (e.g., arrives on time for all meetings; maintains a culturally relevant décor; provides written materials in family/caregiver's primary language; uses trained and sensitive interpreters if needed; inquires about family needs and comfort levels; uses a variety of sincere ways to gain trust).
4. Starts every phone conversation and meeting with sharing of something positive their child has recently done.
5. Calls family member to share positive stories about their child or share accomplishments he/she has made.
6. Does not take family member criticism or anger or frustration personally. Rather works with family member to hear their concerns and identify solutions.
7. Is able to maintain a positive image of each family member and belief in their abilities, even when a family member's/caregiver's behaviors feel frustrating.
8. Allows family members to express their needs and offers support and educational offerings based on their expressed needs.

(c) Staff/program evaluation:

- Ensure family members/partners have input into staff evaluations.
- Ensure family members/partners actively participate in groups that develop and assess different aspects of the program.
- Ensure annual staff performance evaluations and quality improvement initiatives focus on assessing all staff in the competency of family-driven care.

(d) Staff hiring:

- Ensure advertisements include language specific to working in partnership with families.
- Ensure organization hiring practices include questions and protocols that identify potential staff who value families and whose attitudes will support the development of partnerships with families.
- Include family members, children, and advocates in the interviewing process.

(e) Staff supervision:

- Provide all supervisory staff members with extra training and supervision on engaging families, best practice family systems models, and family-driven care practices.

- Put formal supervision in place so every staff member regularly receives feedback on both their personal interaction skills with families and on how they implement practices consistent with family-driven care.
- Ensure informal staff supervision is in place to support in-the-moment recognition and/or teaching based on observations of staff interactions with family members.
- Have supervisors provide staff with opportunities to discuss challenges they face with different family members and offer both support for staff in trying new strategies, as well as a range of successful strategies to try.

(f) Organization printed materials/website:

- Promote respect and sensitivity to families.
- Include positive and diverse images of children and families.
- Are written simply and avoid jargon that may not be understood by family members or the lay public.
- Are reviewed against family-driven care practices.
- Are available in languages the families speak.
- Represent the cultural and ethnic diversity of families served with pictures and examples.

(g) Attention to language and communication:

Family members whose children were served in out of home care have reported that they feel staff communication is often "confusing or lacking." The American Association of Children's Residential Centers (AACRC) (2009) has summarized several steps organizations can take to address this issue. Their suggestions, as well as suggestions from different family members involved in the Building Bridges Initiative, include, but are not limited to:

- Use language that promotes family partnerships and avoids the use of judgmental terms and labels.
- Establish expectations regarding joking or irreverence that could be perceived to be at the expense of the child and/or their families.
- Have live phone attendants to add an element of warmth and personal connection.
- Ensure linguistic competence in the organization by hiring sufficient staff who speak the languages the families served speak.
- Establish relationships with certified interpreters in multiple languages who are committed to respecting and partnering with families. Have certified interpretation services easily available for all activities and meetings.
- Speak clearly and minimize the use of jargon and acronyms. Explain any technical terms that families may not understand.

(h) Continuous Quality Improvement (CQI):

Develop a CQI project to assess adherence to best practices that operationalize family-driven care and focus on successful sustained outcomes for children and families. Examples of data elements to track include, but are not limited to:

- Long-term recidivism with recidivism defined as any out-of-home placement that is not part of the long-term support plan (including hospitalizations).
- # of days each week a child spends time with family.
- # of days each week a child is involved in individualized activities in the community (preferably home community) with pro-social peers (not with fellow children from the program) that match his/her strengths/talents/interests.
- # of times staff call family members weekly to share strengths of and/or positive activities of the child.
- # of times staff call family members to coordinate and communicate changes to the plan of care (i.e., medication changes, etc.).
- # of times child call extended family members and approved friends daily.
- # of times child connect with community support team members weekly (e.g., former team coach or teacher; spiritual leader) by phone and in person.

- Long-term family/community support plans in place, including contact with and and/or plans developed for the following areas: education; recreation; work; spiritual; pro-social peers; and others as identified.

2. Program FDC practices

(a) General supportive practices for engaging families:

- Use parent advocates/partners/peer-to-peer support to connect family members with other family members prior to admission and throughout the residential intervention.
- Ensure organizational policy supports the parental role staying with the family in all aspects of the residential intervention. For example:
  - Families are actively involved in the delivery of care for their children, such as setting the date, time and location of any meetings. If the child and parent are not present, the meeting does not happen!
  - Families are asked to provide their preference for how they would like to be contacted, and their preferred form of communication: text, email, phone, etc.

- Family members are supported in staying connected to their child's current medical providers and/or finding new providers in their home community. Family members schedule and/or are supported in scheduling all medical appointments and accompany their child to these appointments. When necessary, staff members support families in finding transportation and/or accompanying them.
- Families and children are active decision makers in all areas related to medication for their child, including all medication adjustments.
- Schools are notified that the family is the first contact and must be consulted about educational changes. Meetings are arranged at the family's convenience.
- Report cards and school information have the family's signature.
- If the family is unable to supply the child's clothes, the family is provided a clothing allowance and asked to shop with the child. Older children shop for themselves with approval by family. For special events, families shop for their children.
- Families take their child for haircuts/styling. In the very rare instance that this may not be possible, their permission is obtained prior to their children receiving a haircut, and family member preferences are honored whenever possible.

- Program staff receives training and support on cultural and ethnic traditions and practices. They inquire about what families prefer regarding dress, grooming, and other every day practices.

- Develop/revise a family handbook with the help of former and current family members.
- Develop an orientation for new family members with the help of families that recognizes how hard placing a child in out-of-home care can be and provides information about the program. Encourage family members to become leaders and mentor new family members.
- Develop an orientation process with the help of families for family members who serve on a workgroup or committee, including expectations for their role, an explanation of the goals of the specific group, and a partner or advocate to support their participation.
- Implement practices that support child and family spending time together at home, such as:
  - Children are allowed to spend time at home from the first day of the residential intervention.
  - Going home is never a privilege that has to be earned. Children do not 'visit' their homes—they live there and spend time there. If there are safety concerns, alternative plans are made (e.g., staff support; spending time with family members where safety is not a concern) so child can still spend time with family members every week.

- Staff members have frequent communication with multiple family members beginning pre-admission.
- There is a strong focus on supporting children and families in skill-building. Staff goes into the home and community to provide skills training and support for helping family members and children develop and practice skills in their day-to-day environment. Skills are identified with the family and children based on individual strengths and challenges.
- There is a focus on real world skills that children and families can operationalize after transition back to the community rather than skills that are useful in the milieu, but not necessarily applicable in community settings (AACRC, 2009).

- Ensure staff members are knowledgeable about supports and services offered by the child and family-serving systems in each family's home community.
- Ensure services are provided in culturally and linguistically competent environments where family and child voices are heard and respected and everyone feels safe speaking honestly.
- Have staff spend time in the family's home, which is essential to identify treatment and support needs, better understand the culture of the family and community, and understand individual family systems and dynamics.
  - Review all program practices against family-driven care and develop new, family-driven practices.

For instance:

There are no visiting hours for families. They can come to the program 24/7. For example, a number of programs in Massachusetts have changed their practices to enhance their partnerships with families as part of their initiative to implement strength-based care and reduce the use of seclusion and restraint. A few examples of these practices include: Having a cheerful sign at the entrance that welcomes family members; Having 24-hour open visiting hours for family members so that they can spend time with their child any time, including during dinner, at bedtime, before school, etc.; Providing family members with key cards so they can go on campus whenever they want to see their child; Having a protocol to help family members prepare for treatment review meetings so they can be full participants; and connecting families to community parent support networks.

- Order additional phones or allow adolescents to use their cell phones, with appropriate safety and privacy filters, to support frequent contact with their families.
- All holidays and family celebrations in a child's life are with their families in their homes and communities. The role of staff is to support positive family experiences.
- The role of staff is to support families in experiencing fun events together. If the program receives any

tickets, passes or gift certificates, staff should consider how to use them to benefit children and families. For example, residential program in Long Island replaced camping trips for children and staff with camping trips involving families, including siblings, with staff and the children in residential. Staff ensure that the weekend includes activities where all children will be able to shine—building both positive memories for children and their family members together and creating opportunities for families to feel proud of their child. "*Memories should be built with families, not with staff*" (as shared by a family member of a child in the residential program).

(b) Physical environments of the hospital or residential program:

- Ensure physical environments, inside the buildings and on the grounds, reflect the cultural backgrounds of the families served.
- Provide private space at the program for private time between children and their families, including areas for young siblings to play. If possible, a space in the program is available to serve as a family resource center, where families can gather and receive educational and support information.

- Ensure accommodations are made for the size of the family visiting. Some cultures may have 6-8 family members visiting. Any restrictions to a 2- or 3-person limit is changed, and accommodations made according to the preference of the child and family.
- Have physical environments that are inviting, comfortably appointed, and decorated with age and developmentally appropriate supplies. It is important to carefully consider all details, especially how barriers and locks appear, because the message they can convey is one of power and control rather than a warm and hospitable environment.
- Ensure children, families, and staff participate in regular "environmental rounds" of the physical surroundings and in the selection of furniture and furnishings.
- Hang pictures of children and their families in the program (with family's permission) as well as pictures of staff with families—not just with children.
- Ensure bulletin boards throughout the program display school and art work, as well as notable normalized child and family accomplishments, with permission from both children and families (Osher & Huff, 2006).

3. Clinical FDC practices

(a) Family engagement:

- Have organization regularly review their first contact practices. The first contact practices should be welcoming, respectful, culturally and linguistically competent, sensitive to the issues and challenges the family is facing, and empathetic. They are the foundation for building strong relationships moving forward.
- Ensure the unique strengths, interests, and talents of each family member are identified as part of the admission process and shared with staff members.
- Replace traditional treatment team meetings with Child and Family Team/Wraparound or Family Team Conferencing.
- Ensure practices are in place for every child that ensure permanent connections with family members.
- Ensure staff members have skills in building broad support networks in the community and assisting children and families in accessing them.
- Utilize clinical staff titles that emphasize that their main job is to reunite children with families (e.g., from 'case worker' to 'reunification specialists'; from 'clinical staff' to 'permanency coordinator').

- Ensure clinical staff members are hired for their expertise in working with families, preferably using best practices approaches (e.g., wraparound; Multi-systemic Therapy; Family Finding; other family systems models).
- Ensure clinical supervisors in the organization have expertise in utilizing a range of best, evidence-informed and evidence-based practices for working with diverse groups of families and supervising staff on use of the chosen family engagement practices.
- Have the clinical supervision system mirror best practice clinical supervision systems focused on family reunification (i.e., Multi-systemic Therapy).
- Ensure all clinical practices are regularly reviewed against family-driven care and the goal of achieving long-term successful reunification in the community for every child and family served.

Examples of Family-driven Care Clinical Practices across the Country

Residential organizations that are focusing on achieving long-term positive outcomes for children post-discharge have largely shifted from having most clinical work occur in the residential program to having the child receiving clinical services in the community, with family involvement. Hospital and residential clinical staff work with families as in-home therapists/supports focusing on real family issues in real environments.

These same residential organizations have also moved away from having a primary focus on multiple therapeutic groups that occur within the out-of-home care programs. When agencies have evaluated their clinical practices, including asking current and former children what was helpful, they have found that addressing 'real' issues in the home and community are needed. Research validates the importance of focus with children and families as well as ensuring children spend time with pro-social peers **(**Dodge, Dishion, & Lansford, 2006; Weiss, Caron, Ball et al, 2005; Catalano, Berglund, Ryan et al, 1998; Berndt & Keefe, 2005). Some common clinical groups in out-of-home care (i.e. focus on disruptive behavior) have actually been found to be contraindicated (Chorpita & Daleiden, 2007). Organizations must ask hard questions about each of their clinical practices:

- "Does this type of group have evidence of supporting youth post discharge or are we using it because we have always had groups?"
- "Would it be more useful to promote individual youth success in community-based activities, such as music, sports, art, and dance, than attend a group treatment that is not evidence-based?"
- "If working with families in their homes and community has proven to be the critical variable for successful discharges, how should we change our practice and focus to put primary emphasis and time on this area?"

(b) Treatment and support services:

- Ensure families are included in all discussions and decisions about their child.
- Ensure family members have all of the information they need to be informed partners and know and understand the pros and cons of all of the options. Families have sufficient time, the right tools/skills, resources and supports to have a meaningful role in making effective decisions.
- Ensure all evaluations, assessments and treatment/service plans include a strong focus on the strengths, talents, skills, preferences and the unique family culture of each child and family member, as shared by the child and family.
- Ensure the needs on treatment/service plans are based on what the child and family have identified. The plans are developed with the family and their identified supports (e.g., child's coach; big brother; cousin; mother's sister; father's mother).
- Ensure meetings about a child and their family are only held if the child and the family (or their designated representatives) are present. Children and families are encouraged to invite whomever they want to meetings.

- Have a plan in place in case, in the rare event that a family member is not able to physically participate in a meeting, that the meeting is rescheduled for when the family can attend. In a very rare situation, arrangements can be made for a phone or video conference (e.g., Skype), with a staff assigned to ensure and support meaningful family participation throughout the meeting.
- Ensure phone/videoconferences are available for all families whose children are not able to spend time at their specific home frequently (i.e. an out-of-state parent or grandparent). This practice does not preclude children spending time every week with family members in their homes.
- Ensure treatment reviews and therapy meetings are held in the family's home or a community location chosen by the family.
- Ensure program staff members provide ongoing support that is specific to the needs of each child and family throughout the child's stay in the program and post-discharge.
- Ensure there is a direct phone line to an identified staff member or Family Partner or Family Advocate for family members to call if they have concerns at any time or do not know how to handle an issue that arises when their child is at home. They should not have to go through telephonic prompts (AACRC, 2009).

(c) Referral, intake and admission:

Many of the example practices below are most applicable for residential programs:

- Involve families from the beginning with the referral and intake processes, and ensure families are involved in making decisions. When child welfare/court orders do not allow contact between child and one family member, other family members are identified and actively engaged.
- Ensure pre-placement visits and tours are available to families and children, including overnight visits if desired so the child may spend time with peers. These visits include a meal and opportunities for the child and family to learn about the program to determine if the program meets their needs.
- Ensure children and family members are provided with the Building Bridges Initiative Youth and Family Tip Sheets, and staff members review the Tip Sheets with them.
- Ensure the admission day is welcoming, respectful, individualized and culturally sensitive.
- Ensure family partners participate in "test" admission days and provide feedback to program leadership staff to improve first day welcoming and ensure the day is a positive experience for families and children.

- Ensure organization's policy describes the intent, nature and tone of the intake interview and pre-placement visits. All staff members are trained to be welcoming, approachable, and to answer questions from the child and family during the interview and tour. Before the intake or tour is over, staff members explain the structure and expectations of the program. Follow-up phone calls are made to ensure the family and child had all of their questions answered.
- Have peer youth advocates and Family Partners present during intake and admission, to help child and family during this potentially difficult time. Families are given the name and number of another parent and/or a parent partner they can contact with questions.
- Ensure the date and time of the admission are planned so the child does not miss a special activity in his/her home community, and for the convenience of the family.
- Ensure that from the first day of admission, staff, child and family make it a priority to work towards a well-planned discharge that is individualized to the needs of the child and family.

(d) Discharge planning:

- Have discharge planning begin prior to admission and focus on transition to home. Examples of practices that support this focus include, but are not limited to:
  - Clinical staff have expertise in promoting reunification.

- Child and Family Team/Wraparound or Family Team Conferencing are implemented with fidelity.
- The clinical team supports the family and child during the time they are served by the hospital or residential program and post-discharge for an extended period of time.
- During the admission process, children and families decide which services and supports they will need from the residential/hospital program and from the community for the child to return home. Program staff work hard to ensure that as many services and supports as possible are offered in the home and community throughout a child's stay in the program.
- Natural community supports (e.g., home school teacher; coach in the home community; neighbor; extended family member) are identified prior to admission and invited and supported to participate in the wraparound team.
- Peer youth advocates and Family Partners are connected to the family at admission. Their roles are primarily focused on supporting successful transitions home.

- The organization utilizes a 'walk throughout your neighborhood' practice where reunification staff members drive or walk through the family's home community with the child and family and their designated supports. The team members share memories and history with the goal of identifying potential members of a community support team.
- The organization creates funding for reunification specialists, youth advocates and/or Family Partners/Advocates to continue to work with the child and family post-discharge. If the funding is not available, the organization coordinates strong partnerships with community program partners to work with families and children both while in the residential program or hospital and post-discharge.
- If the child is returning to a neighborhood school, the organization reviews the array of school services and supports needed, including communicating the status of school credits.
- The program supports children in maintaining meaningful connections with their community friends with permission from family members and/or the court.
- The program supports child involvement in the school and community activities that he/she was involved with in the past.

San Francisco's System of Care has developed a Family-Driven Care Assessment Tool: "*We embrace family-driven care. Don't we?".* The agency's beliefs are the starting point for the assessment:

- We believe families are expert partners in the care of their children.
- We believe our programs and services should strive to meet the needs of families rather than the other way around.
- We believe families should feel safe, valued, and respected.
- We believe families should have opportunities to develop supportive and trusting relationships within our system.
- We believe in educating, training, and supporting our staff in meeting the needs of families.
- We believe in and "get" families (San Francisco Children's System of Care, 2007).

Next steps for organizations

Moving a program towards family-driven care is a transformational process. Those leading the process must first be committed to family-driven care as a core value for their program. The leaders must also be well-versed in the research that supports family-driven care practices and have a solid understanding of a variety of practices that operationalize the value of family-driven care into practices. The leaders must have both knowledge and skills in the culture change process.

The Six Core Strategies© provide an evidence-based culture change framework. Although the Six Core Strategies©, as originally created by the Substance Abuse and Mental Health Services Administration, focused on reducing the use of coercive interventions, especially restraint and seclusion, the real focus of the Strategies© was culture change towards trauma-informed, recovery-oriented, individualized, strength-based, family-driven and child-guided care.

Leaders who are adept at the Six Core Strategies© and utilize these Strategies© will be using a framework that has proved successful for many organizations around the country (Anthony & Huckshorn, 2008; Huckshorn, 2004; National Association of State Mental Health Program Directors [NASMHPD], 2009).

The field, and methods, for serving children with behavioral and emotional challenges and their families is still evolving. Although many programs have been working on successfully engaging families, implementing a range of family-driven care practices and family systems practices models, much research is still needed to refine and support these practices, and identify new successful strategies.

Family-driven care is sometimes a value and practice area that is not compatible with a number of traditional hospital and residential program practices (e.g., child having to earn time at home; not allowing child to go home for a defined period of time after admission; making time at home contingent on behavior; points and level systems that cannot be replicated at home;

holding treatment team meetings in the program at times designated by and/or convenient for the most staff).

Leaders who embrace family-driven care are beginning a journey that requires staff to re-evaluate long-held beliefs and practices, to implement many new approaches, and to embrace shared decision-making with families. Some staff members may not be able to make the transition to family-driven care and may need to take their talents elsewhere. Culture change is delicate, sometimes painful, and very hard work. This chapter was written to provide all stakeholders with information to support their efforts towards successfully engaging families and operationalizing the value of family-driven care into practices.

Most importantly, it is hoped that this chapter supports all children and families served by residential and/or hospital programs to realize sustained positive outcomes post discharge. Please refer to the *Additional Resources* chapter (Family-Driven Care section) for articles that can support all stakeholders in increasing their knowledge-base about family-driven care.

References

Embracing Family-Driven Care

American Association of Children's Residential Centers (AACRC). (2009). Redefining residential: Family-driven care in residential treatment—Family members speak. *Residential Treatment for Children and Youth, 26*(4), 252-256.

Anthony, W.A. & Huckshorn, K.A. (2008). *Principled leadership in mental health systems and programs*. Center for Psychiatric Rehabilitation. Boston: Boston University Press.

Berndt, T.J. & Keefe, K. (1995). Friends' influence on adolescents' adjustment to school*. Child Development, 66*, 1312-1329.

Blau, G.M., Caldwell, B., Lieberman, R.E. (Eds.). (2014). Residential interventions for children, adolescents, and families: A best practice guide. New York, NY: Routledge.

Building Bridges Initiative (2007, March). Innovative practices for transformation. Unpublished internal workgroup document summarizing comments made by Mark Courtney on a workgroup webinar, p. 26.

Building Bridges Initiative. (2011). *Cultural and Linguistic Competence Guidelines for Residential Programs.* Retrieved March 2, 2012 from http://www.buildingbridges4youth.org/sites/default/files/BBI_CLC_Guidelines_FINAL.pdf.

Casey Family Programs. (2016). Elements of effective practice for children and youth served by therapeutic residential care: Research brief. Seattle: Casey Family Programs. Retrieved on April 20, 2017, http://www.casey.org/media/Group-Care-complete.pdf

References

Catalano, R.F., Berglund, M.L, Ryan, J.A., Lonczak, H.S., & Hawkins, J.D. (1998). Defining and Evaluating Positive Youth Development. *Positive Youth Development in the United States: Research Findings on Evaluations of Positive Youth Development Programs*. Retrieved March 30, 2012 from http://aspe.hhs.gov/hsp/positiveyouthdev99/chapter2.htm

Catholic Community Services of Western Washington (n.d.). *Family search and engagement: A comprehensive practice guide.* Retrieved March 2, 2012 from http://ccsww.org/wp-content/uploads/2017/04/Family_Search_and_Engagement_Guide_CCS-EMQ.pdf.

Chorpita, B.F. & Daleiden, E. L. (2007). *2007 Biennial report: Effective psychosocial interventions for youth with behavioral and emotional needs*. Child and Adolescent Mental Health Division, Hawaii Department of Health. Retrieved March 2, 2012 from http://hawaii.gov/health/mental-health/camhd/library/pdf/ebs/ebs012.pdf

Dodge, K.A., Dishion, T.J., & Lansford, J.E. (2006). Deviant peer influences in intervention and public policy for youth. *Social Policy Report, 20*(1), 3-19.

Dougherty, R; Strod, D; Fisher, S; Broderick, S; & Lieberman, R.E. (2014). Tracking long-term strength-based outcomes. In G.M. Blau, B. Caldwell, & R.E. Lieberman (Eds.), *Residential interventions for children, adolescents, and families: A best practice guide* (pp. 182-194). New York, NY: Routledge.

Huckshorn, K.A. (2004). Reducing seclusion and restraint use in mental health settings: Core strategies for prevention. *Journal of Psychosocial and Mental Health Services, 42*(9), 22-41.

Huefner, J.C, Pick, R.M., Smith, G.L., Stevens, A.L., & Mason, W. A. (2015). Parental involvement in residential care: Distance, frequency of contact, and youth outcomes. *Journal of Child and Family Studies, 24*, 1481–1489. DOI 10.1007/s10826-014-9953-0.

References

Levison-Johnson, J. & Kohomban, J.C. (2014). Linking residential and community. In G.M. Blau, B. Caldwell, & R.E. Lieberman (Eds.), *Residential interventions for children, adolescents, and families: A best practice guide* (pp. 96-109). New York, NY: Routledge.

National Association of State Mental Health Program Directors (NASMHPD). (2009). *Training curriculum for creation of violence-free, coercion-free treatment settings and the reduction of seclusion and restraint, 7th edition*. Alexandria, VA: National Association of State Mental Health Program Directors, Office of Technical Assistance.

National Federation of Families for Children's Mental Health. (2016). Definition of family driven practice (revised 2016). Retrieved from https://docs.wixstatic.com/ugd/c40176_8f9c0267d87f4474a1551c63848187d1.pdf

Osher, T.W., and Huff, B. (2006). *Working With Families of Children in the Juvenile Justice and Corrections Systems: A Guide for Education Program Leaders, Principals, and Building Administrators.* National Evaluation and Technical Assistance Center for the Education of Children and Youth who are Neglected, Delinquent, and At-Risk. Retrieved March 7, 2012 from http://www.neglected-delinquent.org/nd/docs/Family%20Involvement%20Guide_FINAL.pdf.

Uplift. (2017). *Family Search and Engagement*. Retrieved in 2017 from https://upliftfs.org/service/family-search-engagement.

Walters, U. M., & Petr, C. G. (2008). Family-centered residential treatment: Knowledge, research, and values converge. *Residential Treatment for Children and Youth, 25*(1), 1-16.

Weiss, B., Caron, A., Ball, S., Tapp, J., Johnson, M., Weisz J.R. (2005) Iatrogenic effects of group treatment for antisocial youths. *Journal of Consulting and Clinical Psychology, 73*(6), 1036-1044.