To order copies or for information contact:
Massachusetts Department of Mental Health
Child/Adolescent Division
Email: dmhinfo@dmh.state.ma.us
Phone: 617-626-8090
www.mass.gov/dmh

Embracing Family-Driven Care

Beth Caldwell, MS        Anne D. Kupinger, M.Ed.
Joe Anne Hust   Lisa Lambert
Bette Levy, MA, Ed.M., CTRS

"There are two lasting bequests we can give our children. One is roots. The other is wings."

Hodding Carter, Jr.
Embracing Family-Driven Care (FDC)

Introduction

Every residential and hospital program strives to achieve long-term positive outcomes for youth and families post discharge. Some practices that have been used for years have been found to be ineffective, particularly those that focus on staff members' perceived needs of youth. Often, families were viewed as the reason youth experienced problems, were not actively involved until the end of a youth’s treatment, or were engaged by treatment providers using a ‘staff knows best’ approach.

Program leaders did the best they could using the knowledge-base available to them at the time. We now have new practice values that, when operationalized, result in care that correlates to better long-term outcomes for youth and families.

These values are:

- Family-driven;
- Youth-guided;
- Trauma-informed;
- Culturally and linguistically competent; and
- Individualized and strength-based.
This chapter focuses on operationalizing the best practice value of family-driven care (FDC).

There are several studies that support practices consistent with family-driven care. They report improved outcomes when there is increased family involvement, shorter lengths of stay, and stability and support in the post-residential environment (Walters & Petr, 2008). Courtney (2007) finds the strongest predictor of post-transition success from residential treatment, after education, is support from the family. Residential leaders, who look at outcomes of sustained success in the community post-discharge versus youth making improvements between admission and discharge, have found that a primary focus of their work needs to be on working with families in their homes and communities (Dalton, 2011; Kohomban, 2011; Leichtman, M. et al, 2001; Martone, 2010; Hust, 2010).

Every agency 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. Every program making the journey to family-driven care will find it is long and challenging. It is one of the most important journeys that out-of-home programs must make!

To improve outcomes for youth and families, every out-of-home program should develop a comprehensive action plan dedicated to becoming a family-driven service.

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 youth 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 of their disciplines 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

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

The National Federation of Families for Children's Mental Health defines family-driven care as:

"Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation.

This includes:
- Choosing culturally and linguistically competent supports, services, and providers;
- Setting goals;
- Designing, implementing and evaluating programs;
- Monitoring outcomes; and
- Partnering in funding decisions."

(Retrieved February 10, 2012 from http://ffcmh.org/r2/publications2/family-driven-defined/)

The Federation also has identified Guiding Principles for Family-Driven Care. These include but are not limited to: providers sharing decision-making with families and youth; families being provided complete information to make informed decisions and choices; availability of peer support activities; provider leaders allocating staff, training and resources to make family-driven care a reality in their organizations; and, a focus on cultural and linguistic competence.
Families exist in many different forms and perform various roles in the lives of children. In this 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 extend beyond those who have legal responsibility for the child.

Seven areas that have been identified as priority action steps for organizations to implement as part of a family-driven care strategic plan are as follows:

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 as members of their staff. Family Partners are family members who have or are raising a child who has behavioral and/or emotional challenges and has been served in residential and/or hospital programs. Please refer to the section on Successfully Working with Family Partners for more information.

2. **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 http://www.communityinclusion.org/pdf/Sib_brochure_F.pdf and the Massachusetts Sibling Support Network: http://www.masiblingsupport.org/.

3. Ensure that every child realizes permanency with family

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 work with existing family members, legal guardians, and/or, if appropriate, the Department of Children and Families to begin or expand on the work of Family Finding.

EMQ Families First, a multi-service agency serving youth and families in over 30 counties in California, shares the following about Family Finding:

"The Family Finding program of EMQ Families First 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 (EMQ FamiliesFirst, 2012)."

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

"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 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.)."

The Seneca Center for Children and Families in northern CA developed a brochure, "Everyone has Family / Our Kids do Too!" It defines Family Finding in terms of success as the following:

"Success is when at least 40 family members have been identified for the youth. Success is when one or more significant permanent connections have been identified and the relationship is ongoing. Success can also be when the youth's questions about their family have been answered and when a youth knows who they are, where they came from, who loves them and who will be there for them into adulthood. Success is also the when the youth has achieved emotional, physical and/or legal permanency. This includes when the youth, family and team have a plan to support the young person and his/her family, has achieved legal or non-legal commitments and are utilizing resources to maintain permanency (Seneca Center, n.d.)."

There are a number of national organizations that program leaders can contact to increase staff skills in Family Finding. It is essential that all stakeholders embrace a commitment to find permanency and a strong network of support for all youth served in out-of-home care.

4. Create a broad community support network

It is important for every service provider to provide staff training and supervision on how to support youth and families in
building a ‘broad community support network,’ and having it fully in place before the youth returns home. This means identifying a range of extended family members and friends who commit to being a part of a youth's life for many years to come. Staff members support youth and families in defining their needs and work with the identified network members to assess how they can support the needs of the family and youth.

All youth and families should work with their team to develop a plan for when they return home. The plan should include formal services, such as in-home family support or job coaching, and formal supports, such as a church group or membership at the YMCA. Informal supports, such as spending time with extended family members, is also important. The plan should include steps the youth and/or family should take if one or more components of the home/community support plan are not effective. Identifying and successfully engaging a large group of extended family and friends to participate in the home/community support plan increases the likelihood that the youth will experience success.

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

Treatment providers must develop the capacity to successfully support the unique needs of different families. Building clinical staff expertise and providing clinical supervision to ensure sophisticated skills in family systems and fidelity to best practice models is critical. The primary responsibility of all staff
members is to partner with families, not to do things for families. They should be respectful, empathic, and demonstrate strong listening skills.

6. Improve cultural and linguistic competence

Every family deserves to receive services and supports that take into account 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 (The National Building Bridges Initiative Cultural and Linguistic Competence Workgroup, 2011).

It takes a great deal of time and effort to hire staff who culturally and linguistically represent the families served. Many hospital and residential providers have staff who are predominantly white, even when those they serve are predominantly of color. In some programs, staff complain about certain family members, "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 improves, and complaining about or blaming family members decreases. Hiring family partners who represent the ethnicities of families served is a great beginning.
7. Increase the amount of time staff spend working with families in their homes and home communities

Programs should facilitate daily communication between youth and their families and help them spend as much time together as possible at home or in their home communities. The research points to the importance of reversing traditional program practices. Instead of devoting staff time primarily to focusing on youth behaviors and treatment and recreational groups at the program, staff time should shift to working with families in their homes and supporting youth in clinical and recreational activities in their home communities. The primary locus of out-of-home care moves to providing a variety of clinical services in the home and community.

Family-driven care practices

There are many administrative, clinical, and program practices listed throughout this chapter, however, these are just a few examples. There are many other practices that agencies can implement to improve their focus on family-driven care. It is also 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 references at the end of this chapter), feedback from family members and advocates, and experiences of residential and
hospital leaders who have embraced family-driven care as a primary value and practice.

**Administrative FDC Practices**

**(1) Leadership:**

Raquel Hatter, former CEO of a large residential program, went back to her agency after attending the first national Building Bridges 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 family-driven care; and
- Making supervisors accountable to ensuring staff everyday interactions and program practices were family-driven.

- Hire multiple diverse family partners and ensure that there is a lead family partner who serves on the agency's executive team.
- 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.
- Ensure that family members are represented on Boards of Directors and external and internal advisory groups.
- Ensure that there are family groups whose purpose is to provide leadership with feedback on family-driven care.
• Provide family members with multiple avenues to give their input on the work of the organization. For example, an executive leadership team member holds an exit conference with every family when their child transitions back home or all executive leadership practices an open door policy for families.

• Ensure that the organization's mission, vision and values include references/commitment to family-driven care/partnerships with families.

• Create a workgroup about family-driven care, and include committed staff, youth, families and advocates. 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. Leaders articulate and model values and practices in their every day interactions.
- Dedicate resources to supporting families in a variety of ways. For example, paying for travel and lodging, offering stipends for family members to serve on Boards or committees, offering food at events family members attend, paying for baby-sitting services, etc.

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 committed to the following: *Our commitment to each child, youth 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, youth 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, 1/23/12).

- Use data to inform practice and track elements such as recidivism and the number of weekly contacts staff have with family members.

- Ensure multiple family members are represented on agency workgroups and committees and that family members are active participants in all external reviews, such as Joint Commission; COA; and state agency licensing visits. Families should be included at both the entrance and exit meetings.
(2) Staff training:

The CEO is involved in training programs for new staff members and presents an ongoing commitment to best practice values, including family-driven care. In addition, trainings are offered in the following areas:

- Understanding the importance of family-driven care.
- Reviewing agency expectations for engaging, partnering, and respecting families.
- Teaching skills and practices consistent with family-driven care, such as youth calling family members several times a day and staff calling family members daily to share positive feedback.
- Teaching sensitivity to issues involved in out-of-home placement for all family members and that family members may need to heal before they can fully engage in treatment.
- Becoming knowledgeable and sensitive to the unique ethnic and cultural issues and traditions of youth and families.
- Understanding and respecting confidentiality and informed consent.
- Understanding and respecting youth and family rights.
• Supporting family partners as they serve as trainers or co-leaders for both new staff orientation and for regular in-services and their involvement in the development of new training programs.

• Inviting family members to agency training programs and offering the training programs in normalized community locations versus on the residential campus.

(3) Staff/program evaluation:

• Family partners have input into staff evaluations.

• Family partners actively participate in groups that develop and assess different aspects of the program.

• Annual staff performance evaluations and quality improvement initiatives focus on assessing all staff in the competency of family-driven care.

(4) Staff hiring:

• Advertisements include language specific to working in partnership with families.

• Agency hiring practices include questions and protocols that identify potential staff who value families and whose attitudes will support the development of partnerships with families.

• Family members, youth, and advocates are included in the interviewing process.
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.

(5) Staff supervision:
- All agency supervisory staff members receive extra training and supervision on family-driven care.
- Formal supervision is in place so every staff member regularly receives feedback on their personal interaction skills with families and implementing practices consistent with family-driven care.

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• Informal staff supervision is in place to support in-the-moment praise and/or teaching based on observations of staff interactions with family members.

• Supervisors provide staff with opportunities to discuss challenges they face with different family members and offer support for staff in trying new strategies.

(6) Agency printed materials/website:

• Promote respect and sensitivity to families;

• Include positive images of youth 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; and

• Represent the cultural and ethnic diversity of families served with pictures and examples.

(7) 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 (2009) has summarized several steps organizations can take to address this issue. Their suggestions, as well as suggestions from many 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 youth 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.

(8) 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 youth 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;
- # of days each week a youth spends time with family;
- # of days each week a youth is involved in individualized activities in the community;
- # of times staff call family members weekly to share strengths of and/or positive activities of the youth;
- # of times youth call family members daily;
- # of times youth connect with community support team members (e.g., former team coach or teacher; spiritual leader) weekly by phone and in person; and
- Long-term family/community support plans, including contact with and and/or plans developed for the following areas: education; recreation; work; spiritual; pro-social peers; and others as identified.

Program FDC practices

(1) General supportive practices for engaging families:

- Use peer-to-peer support to connect parents with other parents prior to admission and during treatment.

- Agency policy supports the parental role staying with the family in daily practices. 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 youth and parent are not present the meeting does not happen!
➢ Family members schedule medical appointments and accompany their child. When necessary, staff members support families in finding transportation and/or accompanying them.

➢ Families and youth are active participants in all areas related to medication for their child, including all medication adjustments.

➢ Schools are notified that the family is the first contact. 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 youth shop for themselves with approval by family. For special events, families shop for their children.

➢ Families take their child for haircuts/styling. If this is not possible, their permission is obtained prior to their children receiving a haircut.

➢ 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 youth and family spending time together at home, such as:

  ➢ A youth's time at home is determined by the youth and his/her family.
  
  ➢ Youth spend time at home during the first in the program.

  ➢ **Youth NEVER have to earn spending time with families or going home; youth do not 'visit' their homes—they live there and spend time there.** If there are safety concerns, alternative plans are made so youth can still spend time with family members.

  ➢ Staff members have frequent communication with multiple family members beginning at admission.
➢ There is a focus on building skills. Staff goes into the home and community to provide skills training and support for helping parents and youth develop and practice skills in their day-to-day environment. Skills are identified with the family and youth 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).

▪ Staff members are knowledgeable about supports and services offered by the child and family-serving systems in each family's home community.

▪ Services are provided in culturally and linguistically competent environments where family and youth voices are heard and respected and everyone feels safe speaking honestly.

▪ Staff spend time in the family's home which is essential to identify treatment and support needs, to better understand the culture of the family and community, and to 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.
Successful practices in Massachusetts

A number of programs in Massachusetts have changed their practices to enhance their partnerships with families as part of their initiatives 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 parent support networks.

➢ Order additional phones or allow adolescents to use their cell phones to support frequent contact with their families.

➢ All celebrations in a youth'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 youth and families.
"Memories should be built with families, not with staff" (family member of a youth in residential). A residential program in Long Island replaced camping trips for youth and staff with camping trips involving families, including siblings, with staff and the youth in residential. Staff ensure that the weekend includes activities where all youth will be able to shine—building both positive memories for youth and their family members together and creating opportunities for families to feel proud of their child.

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

- Physical environments, inside the buildings and on the grounds, reflect the cultural backgrounds of the families served.

- Private space is available for private time between youth 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.

- Physical environments 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.
• Youth, families and staff participate in regular "environmental rounds" of the physical surroundings and in the selection of furniture and furnishings.

• With family permission, pictures of youth and their families are hung in the program as well as pictures of staff with families and youth.

• Bulletin boards throughout the program display information about school activities. With permission from individual youth, samples of academic and creative work may be displayed (Osher & Huff, 2006).

Clinical FDC practices

(1) Family engagement:

• The agency regularly reviews 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.

• The unique strengths, interests, and talents of each family member are identified as part of the admission process and shared with staff members.

- Practices are in place for every youth that ensure permanent connections with family members.

- Staff members have skills in building broad support networks in the community and assist youth and families in accessing them.

- Clinical staff titles 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').

- Hiring practices ensure that clinical staff members are hired for their expertise in working with families, preferably using best practices approaches (e.g., wraparound; Multi-systemic Therapy: http://mstservices.com/; family systems).

- Clinical supervisors in the organization have expertise in utilizing a range of best practices for working with diverse group of families and experience in supervising staff members.

- The clinical supervision system mirrors best practice clinical supervision systems focused on family reunification (i.e., Multi-systemic Therapy).

- 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 organization that are focusing on achieving long-term positive outcomes for youth post-discharge have largely shifted from having most clinical work occur in the residential program to having the youth 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 multiple therapeutic groups in out-of-home care programs. When agencies have evaluated their clinical practices, including asking current and former youth what was helpful, they found that multiple groups with peers from the residential program were not helpful. Research validates this, supporting the priority need for youth to 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 groups in out-of-home care (i.e. 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?"

- Families and youth are involved in planning and selecting what will be done. Families are included in all discussions and decisions about their child.
- Family members have all of the information they need to be informed partners and that they 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 good decisions.

- All evaluations, assessments and treatment/service plans include a strong focus on the strengths, talents, skills and the unique family culture of each youth and family member, as shared by the youth and family.

- Needs on treatment/service plans are based on what the youth and family have identified. The plans are developed with the family and their identified supports (e.g., youth's coach; big brother; cousin; mother's sister; father's mother).

- Meetings about a youth and their family are held if the youth and the family (or their designated representatives) are present. Youth and families are allowed to invite whomever they want to meetings.

- In the event that a family member is not able to physically participate in a meeting, arrangements are made for a phone or video conference (e.g., Skype).

- Phone/videoconferences are available for all families whose children are not able to spend time at home frequently.
- Treatment reviews and therapy meetings are held in the family's home or a community location chosen by the family.

- 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.

- 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).

(2) Referral, intake and admission:

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

- Beginning with the referral and intake processes, families are involved in making decisions. When child welfare/court orders do not allow contact between youth and one family member, other family members are identified and actively engaged.

- Pre-placements visits and tours are available to families and youth, including overnight visits if desired so the youth may spend time with peers. These visits include a meal and opportunities for the youth and family to learn about the program to determine if the program meets their needs.
- Youth and family members are provided with the Building Bridges Initiative Youth and Family Tip Sheets (www.buildingbridges4youth.org), and staff members review the Tip Sheets with them.

- The admission day is welcoming, respectful, individualized and culturally sensitive.

- 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 youth.

- Agency 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 youth 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 youth had all of their questions answered.

- During intake and admission, peer youth advocates and Family Partners are present to help youth 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.

- The date and time of the admission are planned so the youth does not miss a special activity and for the convenience of the family.
From the first day of admission, staff, youth and family make it a priority to work towards a well planned discharge that is individualized to the needs of the youth and family.

(3) Discharge planning:

- Discharge planning and focus on transition to home and the community begin prior to admission. 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 wraparound team identified supports the family and youth both 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, youth and families decide which services and supports they will need from the residential/hospital program and from the community for the youth 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 youth 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 youth and family post-discharge. If the funding is not available, the organization coordinates strong partnerships with community program partners to work with families and youth both while in the residential program or hospital and post discharge.

➢ The program supports youth in maintaining meaningful connections with their community friends with permission from family members and/or the court.
The program supports youth involvement in the school and community activities that he/she was involved with in the past.

How different programs across the country have implemented family-driven care principles

The **Parent Advocacy Program** in Jefferson County, Kentucky, established in 2004, is an example of an initiative that has successfully navigated the challenges of implementing family-driven care. This program selects and trains parents, who were previously recipients of child-welfare services to be peer advocates to parents whose children are currently being served by the child-welfare system. Parent Advocates and child welfare staff work together to prevent the removal of children from their homes, reunify children with their families, maintain connections between parents and children who are in out-of-home care, and help train workers and foster parents on the needs of birth parents (Spencer, Blau & Mallery, 2010).

**North Carolina** implemented a policy that meetings and discussions about the child do not occur unless the child and parent are present. The State facilities also provide transportation for families and have broadened visitation rules to allow families unlimited access seven days a week (Osher & Huff, 2006).
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.

Examples from NYS OMH Children's Community Residence Programs in NYC:

At Jewish Board of Family and Children's Services, Ittleson Residence:

- Families are encouraged to join their child for dinner at the residence, to help with homework, to tuck the child in each night, or to call and read a bedtime story or to just say good night, keeping some of the same routines they had prior to placement.
- Program staff call family members daily to share something positive the youth has done or just to inquire about the family member is doing.

At SCO Family of Services, Our Place Residence:

- When staff receives donations or free tickets to attend community events such as Broadway shows and professional sports events, youth are given tickets to invite their siblings, cousins or friends to go with them. If needed, staff attends to support families. Family outings are planned to amusement parks, movies and families are encouraged to bring extended family members so the youth does not lose touch with their extended family.

At Institute of Community Living, Linden House Residence:

- The discharge plan begins at admission. To ensure that the transition to home and community is seamless, families are offered a long trial discharge period, where the youth time at home increases by a day or two each week until they are home seven days a week. Once the discharge date is scheduled, the youth returns to school in their home district school while the youth is still a resident at the community residence. The family is able to reconnect the youth in community activities while they still have the support of the community residence staff to guide and assist them with any challenges. This gradual transition takes into account the family dynamics of separation and affords both the youth and the rest of the family time to adjust to having the youth living at home.
full time. It assists with the youth’s reintegration to their home community (Bette Levy, former NYC Field Coordinator, New York State Office of Mental Health, personal communication, 1/23/12).

**What Families and Youth Say Needs to Change:**
- Service delivery and supports need to be strengthened and expanded.
- Research, treatment, and supports must include enhanced roles for families and youth and increased access to outcomes data.
- Service array within the mental health system, across child-serving systems, and in different settings must be responsive to community needs and lead to positive youth outcomes.
- Racial and ethnic disparities need to be addressed.
- Stigma must be eliminated.
- Custody relinquishment in exchange for services must be eliminated.
- Funding policies that lack flexibility or foster dependence should be reformed.
- Quality care and positive outcomes should be the prevailing standard for all services and supports, including residential treatment (Dababnah & Cooper, 2006).

**Next steps**

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 family-driven care. The leaders must have both knowledge and skills in the culture change process. The Six Core Strategies® provide a solid framework for large culture change initiatives.
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 youth-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; NASMHPD, 2009).

The field and methods for serving youth with behavioral and emotional challenges, and their families is still evolving. Family-driven care is a relatively new practice for out-of-home services. It is also a value and practice area that is not compatible with a number of traditional hospital and residential program practices (e.g., youth having to earn time at home; not allowing youth 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 staff).

Leaders who embrace family-driven care are beginning a journey that requires staff to re-evaluate long-held beliefs and practices, to implement a number of new approaches, and to embrace shared decision-making. 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 effort towards family-driven care and to ensure that all
youth and families served by their residential or hospital
program achieve long-term positive outcomes. 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.

Additional resources

A working definition of family-driven care by the Federation of
Families for Children's Mental Health is included at the end of
this chapter.
Definition of Family-Driven Care
Family-driven means families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes:

✓ Choosing culturally and linguistically competent supports, services, and providers;
✓ Setting goals;
✓ Designing, implementing and evaluating programs;
✓ Monitoring outcomes; and
✓ Partnering in funding decisions.

Guiding Principles of Family-Driven Care

1. Families and youth are given accurate, understandable, and complete information necessary to set goals and to make choices for improved planning for individual children and their families.

2. Families and youth, providers and administrators embrace the concept of sharing decision-making and responsibility for outcomes.

3. All children, youth, and families have a biological, adoptive, foster, or surrogate family voice advocating on their behalf and may appoint them as substitute drivers at anytime.

4. Families and family-run organizations engage in peer support activities to reduce isolation, gather and disseminate accurate information, and strengthen the family voice.

5. Families and family-run organizations provide direction for decisions that impact funding for services, treatments, and supports and allows families and youth to have choices.

6. Providers take the initiative to change practice from provider-driven to family-driven.

7. Administrators allocate staff, training, support and resources to make family-driven practice work at the point where services and supports are delivered to children, youth, and families and where family and youth run organizations are funded and sustained.

8. Community attitude change efforts focus on removing barriers and discrimination created by stigma.

9. Communities embrace, value, and celebrate the diverse cultures of their children, youth, and families and work to eliminate mental health disparities.

10. Everyone who connects with children, youth, and families continually advances their own cultural and linguistic responsiveness as the population served changes.
Embracing Family-Driven Care

*Note: Some of the ideas within this chapter were influenced by the NYS OMH Valuing Families article


References


References


References


