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WHITE PAPER

The Future of Family Engagement in Residential Care Settings

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In Collaboration with The Residential Care Consortium

EXECUTIVE SUMMARY

Residential programs for children and youth are increasingly implementing engagement strategies to promote family-centered and family-driven models of care (Leichtman, 2008). The practice of engagement is a fairly new area of...
research, especially in residential care. Prior to implementing a family-centered approach to care, residential administrators and key stakeholders will want to consider the existing knowledge base of evidence-based activities and implementation strategies.

Driven by their goal to increase the use of state-of-the-art family engagement and family-centered models of care in members' organizations, the Residential Care Consortium (RCC), a five-year-old collaborative of eight private, nonprofit child caring agencies, partnered with Coordinated Care Services, Inc. (CCSI), a not-for-profit management services organization with specific expertise in the areas of behavioral health and human services, to develop a white paper that would make a definitive statement regarding the use of best practices and evidence-based approaches for family-centered care in residential settings. The paper explored the best practice elements and evidence-based approaches for family-centered practice and the family engagement strategies with documented outcomes. Other emerging practices within residential care and the steps needed to promote a culture and practice change initiative within residential settings were presented in order to fully inform a plan for implementation.

Specific recommendations emerged from the synthesis of the literature, and align with current policy and advocacy efforts surrounding family-centered and family-driven care models. It is imperative to note that the dearth of research on family engagement strategies and family-centered models of care does not allow for precise recommendations to be made on individual engagement activities. Broader recommendations are made for service delivery options or program models instead. The following recommendations are made in the white paper:

1. **Involve parents or guardians in the active delivery of care for their children.** Research (Chao, Bryan, Burstein, & Ergul, 2006; Kalke, Glanton, & Cristalli, 2007; Martone, Kemp, & Pearson, 1989) suggests that the practice of parents playing an active role in the delivery of care for their children may be an effective strategy for residential care. Programs can train parents in effective intervention practices, have parents implement these strategies within the treatment milieu, and support parents in reinforcing these behaviors at home. This kind of collaboration with parents is also backed by the Building Bridges Initiative (2008b) in their performance guidelines and indicators matrix and the American Association of Children's Residential Centers (AACRC; 2006) in their position paper on family-driven care.

2. **Utilize system of care principles, particularly the wraparound approach and focus attention on transition services, as a mechanism to move toward implementation of family-driven strategies.** Systems of care and family-centered approaches such as the wraparound approach and child and family team process (e.g., Sedgwick County
Community Mental Health Center, and St. Charles Youth and Family Services) are promising methods of increasing family-centered practice in a residential setting. These efforts, coupled with focused attention on transition (e.g., Damar Services [Building Bridges Initiative, 2008a]; Knecht & Hargrave, 2002; Landsman, Groza, Tyler, & Malone, 2001; Leichtman, Leichtman, Barber, & Neese, 2001; Pierpont & McGinty, 2004), reflect the applied use of system of care principles and approaches in residential facilities or treatment centers. Child and family teams and practices that promote continuity in transitions from care are also recommended by AACRC and in the Building Bridges performance guidelines (AACRC, 2006; Building Bridges Initiative, 2008b).

3. **When implementing family engagement strategies or family-centered interventions, utilize assessments that adequately identify factors that may alter the strategies' or interventions' effect on outcomes.**

The literature identified several factors that may moderate the effect of family engagement strategies (e.g., Dempsey & Keen, 2008). In order to truly learn which family engagement or family-driven strategies are effective, it will be necessary to evaluate the direct connection between strategies and outcomes. Standardized assessments that can identify important variables, such as the influence of caretaker supports or caretaker demographic characteristics, can assist agencies in achieving long-term effectiveness with regard to engagement strategies. Other influential variables may be uncovered that are unique to certain populations, which supports a culturally competent approach to implementation.

4. **Implement evidence-based strategies that reduce initial barriers to engagement.**

Engagement strategies have been incorporated as a component of evidence-based programs and are the first step in care delivery (Connell, Dishion, Yasui, & Kavanagh, 2007; Szapocznik & Williams, 2000). Residential facilities should explore the application of these approaches to their settings. At the very least, residential centers can begin to explicitly explore barriers to program success with families, which was a strategy utilized in several settings (Aeby, Manning, Thyer, & Carpenter-Aeby, 1999; Connell et al., 2007; McKay, Hibbert, Hoagwood, Rodriguez, Murray et al., 2004; Szapocznik & Williams, 2000).

5. **Offer family therapy and parenting education to the extent possible.**

Family therapy is a common element among several programs mentioned in this paper and has been linked with positive results in residential treatment facilities (e.g., Gorske, Srebalus, & Walls, 2003; Stage, 1999). Residential treatment centers will need to select family therapy approaches and parenting skills educational opportunities based on the needs of their specific population.

6. **Integrate parent mentors into practice settings who have previously had a child in residential care.**
The use of parent mentors who have experienced similar challenges has been linked to a number of positive parent outcomes and a few child outcomes, mainly in the medical literature (e.g., Ireys, Sills, Kolodner, & Walsh, 1996). Some residential facilities have embraced this practice (e.g., Hathaway-Sycamores). Also, the AACRC (2006) and Building Bridges Initiative (2006) recommend hiring or involving parents who have had children in residential treatment. The application of this practice beyond the health or medical setting is in need of further exploration but appears to be a promising practice that has begun to be used in residential settings.

A structured framework to guide the implementation of one or more of the aforementioned recommendations can be found within the theory of change and logic model process, which has been suggested as a tool for evidence-based practices implementation and system transformation efforts, particularly in systems of care (Hernandez & Hodges, 2005). The logic model provides the framework to graphically represent the theory of change by identifying and linking the population of focus, strengths and resources, outcomes, and the proposed strategies to achieve defined outcomes. To determine the practical steps for implementing and evaluating the chosen strategy, residential facilities may want to consider the Getting to Outcomes (GTO) framework (Fetterman & Wandersman, 2005). Based on the principles of empowerment evaluation, which include democratic participation, accountability, capacity building, inclusion, community ownership, and social justice (Chinman, Imm, & Wandersman, 2004), GTO offers a straightforward process for examining several practical implementation steps which fall into three broad categories: planning, evaluation, and sustainability.

Assessing organizational readiness has also been identified as an important change strategy process in the literature. Specifically, agencies may want to consider an assessment for organizational change (e.g., Organizational Social Context [Glisson, Landsverk, Schoenwald, Kelleher, Hoagwood et al., 2008]; Organizational Readiness for Change scale [Lehman, Greener, & Simpson, 2002]). Training is another critical step for implementation. Scales that have assessed training needs in other settings may be applicable to residential centers (e.g., Program Training Needs [Rowan-Szal, Greener, Joe, & Simpson, 2007]). Participating organizations may also want to consider a learning collaborative approach, which brings together teams from several programs during the implementation process to receive training and/or discuss challenges and strategies to implementation and which focus intentionally on continuous quality improvement efforts (Cavaleri, Gopalan, McKay, Appel, Bannon et al., 2006; Institute for Healthcare Improvement, 2008).

From the literature, it is apparent that the field of health and human services is actively exploring mechanisms that will support the move toward family-driven care. While there is a dearth of literature that explicitly demonstrates outcomes from these approaches, much exists to support this shift
in thinking. Moving in the direction of family-driven care can clearly add value to any residential program and will likely contribute to some improvement in the outcomes for children and their families.

BACKGROUND

The RCC is a five-year old collaborative of eight private, nonprofit child caring agencies. Consortium agencies provide residential and community-based services to children who have been referred by various sources such as child welfare or the juvenile justice systems or the child’s parent or guardian. RCC members’ services range from short- to long-term treatment and include an array of residential programs, adoption and foster care, early childhood development, and vocational training. Driven by their goal to increase the use of state-of-the-art family engagement and family-centered models of care in members’ organizations, the RCC requested a proposal for the development of a white paper that would make a definitive statement regarding the use of best practices and evidence-based approaches for family-centered care in residential settings. Coordinated Care Services, Inc. (CCSI), a not-for-profit management services organization with specific expertise in the areas of behavioral health and human services, was awarded the contract to research and write the white paper.

INTRODUCTION

Family involvement, evidence-based practices, and outcomes measurement are a few of the current trends in residential treatment that set the stage for a transformation in the field (Lieberman, 2004). Family involvement in residential treatment has emerged only in the past few decades (Leichtman, 2008). By the late 1990s, family-centered principles began to gain momentum in residential settings. Provider and advocacy groups concerned with best practices in residential treatment, such as the AACRC (2006) and the Building Bridges Initiative (Stroul, 2007), have developed policies around family-driven principles and family involvement.

While there is limited evidence on the overall effectiveness of residential treatment (Burns, Hoagwood, & Mrazek, 1999), reviews of the empirical literature point to the positive connection between family involvement and outcomes for children in residential care or treatment (Frensch & Cameron, 2002; Hair, 2005; Knorth, Harder, Zandberg, & Kendrick, 2008). Despite these findings, inherent challenges to instituting family involvement as common practice in residential facilities remain, such as lack of expertise and resources for staff (Barth, 2005). As Whittaker (2000) notes, residential care providers are limited by the underdeveloped knowledge base for family engagement.
principles and strategies. Family engagement activities may be used to promote and build family-centered models of care; however, given the broad definitional and conceptual use of family engagement (Yatchmenoff, 2005), it is not surprising that a consistent and effective method of engaging families is not available for residential services or the entire human service delivery system.

According to Walter and Petr (2008), enhancing family contact, involving families in the planning and delivery of treatment and care for their children, and maximizing after-care support are the overarching strategies recently implemented in residential care to create a family-centered environment. Some specific examples of family involvement include inviting families to participate on Boards of Directors, creating parent advocate positions, and training staff and families together. According to the results of a survey conducted by Abt Associates (2008) with residential treatment members of the National Association for Children’s Behavioral Health (NACBH) and the National Association of Psychiatric Health Systems (NAPHS), the majority of programs included families in discharge planning (94%), treatment planning (93%), admission policy (76%), and programming (57%). A number of programs also included families in quality assurance (34%), risk management (26%), governance activities such as board or committee work (11%), and provided a family liaison (48%).

Results from a study (Nickerson, Brooks, Colby, Rickert, & Salamone, 2006) that captured family, staff, and adolescent perspectives in a residential facility suggested that family involvement was occurring more frequently compared to earlier research. While promising approaches for family-centered care in the residential setting exist (Nickerson et al.; Walter & Petr, 2008), the evidence supporting the success of these practices is limited (Walter, 2007). This paper seeks to further explore the knowledge base on the use of family engagement practices and family-centered practices in residential programs and treatment centers, identify evidence-based and best practices approaches, and recommend specific strategies based on the research for residential providers.

Research Questions

Four specific research questions drive the structure of this paper:

1. What are the best practice elements and evidence-based approaches for family-centered practice?
2. What family engagement strategies are most essential and have the most power in producing the desired effect(s)?
3. What other emerging and innovative practices exist in residential care?
4. What are the critical steps needed to promote a culture and practice change initiative within residential care settings?
Terms and concepts will be defined, along with methods used for searching the literature and gathering pertinent information. Findings from the literature, in response to the three previously outlined questions, will be presented first, followed by specific recommendations for the implementation of family engagement and family-centered practices in residential treatment facilities. Question 4 will be answered following the initial practice recommendations as a means to set the stage for potential implementation of recommendations put forth in the preceding three questions.

Definitions

The following definitions are provided as a guide for the topics discussed in this paper:

1. **Evidence-based**: Several definitions of evidence-based practice are available across human service fields. Considering the lack of definitional consistency, we did not settle on just one definition to frame our search. The American Psychological Association (2005) defines evidence-based practices as “the integration of the best available research with clinical expertise in the context of patient characteristics, culture, and preferences” (p. 1). This definition has been referred to, but not accepted as the only definition, in discussions on evidence-based practices in children’s mental health services (Lieberman, Martinez, Zubritsky, Fisher, Kramer et al., 2009) and residential services (American Association of Children’s Residential Centers, 2008). Several references to research in this paper utilize the APA’s definition. We also defined evidence-based practice as, “Basing clinical practice and decision making on the appraisal of systematic research findings” (Tuleya, 2007, p. 16). This description was found in the PsycINFO database search engine, which was the primary source for the literature used in this paper.

2. **Family-centered practice**: Family-centered practices promote communication and collaboration with parents and guardians, allow for individualized treatment based on informed decision-making, provide supports that enable families to best meet their own needs, and endorse an overall respectful atmosphere toward families (Dunst, 2002). The term *family-driven care* denotes a similar context, but also purports that families are empowered to make decisions and are involved in policies and procedures guiding administrative processes such as oversight and program implementation (National Federation of Families for Children’s Mental Health, 2008). Such activities were also explored in this paper.

3. **Family engagement**: In the clinical and empirical literature, engagement has been explored and conceptualized within the care process, from initial contact through participation in treatment activities (Yatchmenoff, 2005). Family engagement will be broadly defined here as any level or
type of participation by parents, guardians, or other family members of children receiving services. Family engagement activities may include, but not be limited to: (a) planning and decision-making, (b) education and skill-building, (c) relationship-building/recreation, (d) involvement in direct clinical services, (e) transition planning, and (f) provision of after-care supports. To delineate between family-centered practices and engagement, engagement strategies will be understood as the specific actions that promote family-centered practices (e.g., phone calls to families).

4. Residential care\(^1\): An agreed-upon definition of residential treatment has not been determined in the field (Butler & McPherson, 2007). To incorporate the multiple views from residential providers on the types of services they offer, for the purposes of this paper, residential care is defined as any program that provides 24-hour out-of-home care to children and youth. Residential programs encompass an array of service options which may include but are not limited to: educational support and programming, skill-building, social skills development, recreation, counseling, therapy, and family interventions. Residential programs, residential settings, residential services, and residential care will be used interchangeably. Residential treatment will be used when there was a clear indication that it was the selected term.

**METHODOLOGY**

The content of this white paper was informed by peer-reviewed journal articles, book chapters, experts in the field of engagement, and residential care or treatment, and leaders in the implementation of family-centered care. The literature was searched primarily in the PsycINFO and social work abstracts databases using a combination of the following search terms: engagement, evidence-based practice, family-centered, and family-driven. The general and broad use of the terms family engagement and family-centered in the literature suggests that evidence behind these practices may be found in articles on other topics such as general child welfare or family-based interventions; however, in order to present a clear-cut, systematic framework for the implementation of engagement practices in residential settings, we primarily used evidence-based as a keyword with a combination of engagement, family-driven, or family-centered. The research was limited to the past decade (i.e., from 1999–2009) unless the study was conducted within a residential care setting and provided evidence of outcomes. With the exception of the innovative practices section, studies were only included if specific references were made to engagement or family-centered care in the narrative describing the program or practice.

The AACRC (2008) cautions that while evidence-based practices present a significant and important opportunity for meeting families’ needs in residential centers, these practices may lack evidence with diverse populations,
may be limited in the range of presenting problems they attempt to alleviate, may not reflect organizational dynamics, and may not consider the unique components of the care process, such as the development of the helping relationship. To this end, we reviewed several additional resources found in the reference lists of articles located through the database search. We also consulted with Kari Behling, National Director of the AACRC, to gather perspectives on the topic and further advice on the search, and reviewed the abstracts of almost 200 articles using *family-centered* as the only search term. Margaret Coombes, LMSW, a researcher in child welfare engagement, provided a collection of articles and papers; Dr. Mary McKay, a leading researcher in mental health engagement, offered information on engagement practices and associated research and other relevant articles; and Dr. Barbara Friesen from the Research and Training Center on Family Support and Children’s Mental Health at Portland State University supplied papers she and colleagues wrote on their systems of care research. In addition to previous work completed by CCSI, several compilations of the literature on residential treatment were made available and were essential resources. A few references cite personal communications or presentations at conferences.

**REVIEW OF THE LITERATURE**

The literature search produced a number of themes supporting the use of engagement techniques and family-centered care in residential settings. These themes are presented below. We were not able to identify strong links between individual best practice approaches and outcomes. When comparing among studies, we also did not find trends on specific evidence-based engagement practices. Rather, much of the research was conducted on programs that embodied a family-centered approach or utilized several engagement strategies and evaluated the effect of that program on youth or family outcomes. Tables 1 through 5 provide a summary of the following literature.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Martone, Kemp, &amp; Pearson, 1989</td>
<td>None cited</td>
<td>Shorter stays in residential care by almost 50%</td>
</tr>
<tr>
<td>Chao, Bryan, Burstein, &amp; Ergul, 2006</td>
<td>Assessments of language development and behaviors</td>
<td>Children scored significantly better on assessments of language development and behaviors compared to children in non-intervention group</td>
</tr>
<tr>
<td>Kalke, Glanton, &amp; Cristalli, 2007</td>
<td>Number of support room referrals, Number of safety holds in residential care</td>
<td>Significant decrease in support room referrals, Significant decrease in safety holds</td>
</tr>
</tbody>
</table>
TABLE 2 Programs that Represent System of Care Philosophy and the Wraparound Approach

<table>
<thead>
<tr>
<th>Reference</th>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sedgwick County Community Mental Health Center (J. Patterson, personal communication, April 26, 2008)</td>
<td>• Length of stay • Length of stay • Child and Adolescent Functional Assessment Scale • Restrictiveness of setting following enrollment</td>
<td>• On average, youth discharged at 90 days and seldom in care past 150 days • Length of stay decreased over time and was at 3 to 4 months in 2007 • Significant improvement in functioning</td>
</tr>
<tr>
<td>St. Charles Youth and Family Services, Inc. (Building Bridges Initiative, 2008a)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dawn Project (Anderson, Wright, Kooreman, Mohr, &amp; Russell, 2003)</td>
<td>• Caregiver visits • Length of stay • Discharge location • Stability of placement following treatment • Clinical assessments • Length of stay • Recidivism</td>
<td>• Increase in youth living in less restrictive setting 12 months following enrollment • Results from pilot study; measures unavailable • Parent involvement influenced positive outcomes (data unavailable) • Social supports and mental health services influenced ongoing behavioral progress and stability (data unavailable) • REPARE youth significantly more in-person visits than comparison group youth • REPARE youth significantly more likely to be discharged home than comparison group youth • REPARE youth significantly more likely to remain in stable placements than comparison group youth • Greater likelihood of improved clinical functioning compared to non-pilot youth • Shorter lengths of stay compared to non-pilot youth • Greater likelihood of discharge to families’ or relatives’ homes compared to non-pilot youth • Children in pilot less likely to be readmitted following treatment (30 and 180 days following discharge)</td>
</tr>
</tbody>
</table>
These tables present a snapshot of key findings with respect to Research Questions 1 through 3, including indicators or instruments associated with positive results, and outcomes.

Research Question 1: What are the best practices elements and evidence-based approaches for family-centered practice?

There were four main findings to this question, which will be discussed:

- Programs that actively partner with families in the delivery of care reflect positive outcomes.
- Programs that subscribe to system of care philosophy and the wrap-around approach produce positive outcomes.
- The outcomes of family engagement strategies or family-centered practices are mediated or moderated by other variables.

<table>
<thead>
<tr>
<th>Reference</th>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carolinas Project (Alwon et al., 2000)</td>
<td>Trieschman Family Centered Group Care Instrument</td>
<td>Significant increases in availability of family-specific services</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Significant increases in parent involvement and parent decision making</td>
</tr>
<tr>
<td>Leichtman, Leichtman, Barber, &amp; Neese, 2001</td>
<td>Assessments of youth behavior and functioning</td>
<td>Statistically significant and clinically significant improvements on behavioral and mental health assessments 12 months following discharge from psychiatric facility</td>
</tr>
<tr>
<td>Byalin, 1990</td>
<td>Length of stay</td>
<td>Shorter stays</td>
</tr>
<tr>
<td></td>
<td>Family outcomes</td>
<td></td>
</tr>
<tr>
<td>Knecht &amp; Hargrave, 2002</td>
<td>Length of stay</td>
<td>Decline in length of stay from 14 months to 9 months</td>
</tr>
<tr>
<td>Lakin, Brambila, &amp; Sigda, 2004</td>
<td>Family therapy attendance</td>
<td>Family functioning at discharge correlated with family therapy attendance</td>
</tr>
<tr>
<td></td>
<td>Family functioning</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Phone calls</td>
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<tr>
<td>Reference</td>
<td>Indicator</td>
<td>Outcome</td>
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</tr>
<tr>
<td>Adolescent Transition Program (Connell &amp; Dishion, 2008)</td>
<td>Depression assessments</td>
<td>Depressive symptoms did not significantly increase over a 3-year period compared to a control group</td>
</tr>
<tr>
<td>Adolescent Transition Program Family Check-Up (Connell, Dishion, Yasui, &amp; Kavanagh, 2007)</td>
<td>Self-report survey on substance use</td>
<td>Less increase in substance use and behavioral issues from 11 to 17 years of age for youth whose parents received Adolescent Transition Program (ATP) with the Family Check-Up (FCU) compared to youth whose parents received ATP without FCU and compared to a control group</td>
</tr>
<tr>
<td></td>
<td>Behavioral assessments</td>
<td>Children whose parents received FCU exhibited decrease in likelihood for arrest and substance use at 18 years of age</td>
</tr>
<tr>
<td>Adolescent Transition Program: Family Resource Center component of ATP (Stormshak, Dishion, Light, &amp; Yasui, 2005)</td>
<td>Arrest records</td>
<td>Growth in youth problem behaviors significantly reduced for schools utilizing family resource centers</td>
</tr>
<tr>
<td></td>
<td>Problem behaviors</td>
<td>Higher rates of attendance retention than community comparison</td>
</tr>
<tr>
<td>Strategic Structural Engagement Strategy in Brief Strategic Family Therapy (Coatsworth Duncan, Pantin, &amp; Szapocznik, 2006; Szapocznik et al., 1988)</td>
<td>Various measures of attendance and retention</td>
<td>Decrease in delinquency recidivism and out-of-home placement</td>
</tr>
<tr>
<td></td>
<td>Various youth measures</td>
<td>60% to 100% child attendance rates (compared to attendance rate of 50%)</td>
</tr>
<tr>
<td></td>
<td>Attendance rates from 1st to 2nd contact</td>
<td>Parents’ level of motivation correlated with attendance</td>
</tr>
<tr>
<td></td>
<td>Attendance</td>
<td>When staff perceived that participants had a lower understanding of the program, attendance rates were higher (staff may have spent more time with participants who they felt had a lower level of understanding)</td>
</tr>
<tr>
<td></td>
<td>Level of motivation</td>
<td>Compared to students who did not receive the program, students in the experimental group displayed statistically significant higher grades at discharge</td>
</tr>
<tr>
<td>Pinto et al., 2007</td>
<td>Grades</td>
<td>Higher attendance rates during and following program completion</td>
</tr>
<tr>
<td></td>
<td>Attendance rates</td>
<td>Lower rates of dropout 150 days following discharge</td>
</tr>
<tr>
<td>Alternative School Program (Aeby, Manning, Thyer, &amp; Carpenter-Aeby, 1999)</td>
<td></td>
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</table>
• The value of family contact, communication, and partnership between parents and staff, and an active decision-making role for parents in regard to their child’s care is also supported by research that explores family and provider perspectives

A. Programs that actively partner with families in the delivery of care reflect positive outcomes.

The parents’ continued role in caretaking throughout the delivery of the interventions was emphasized in a few programs. Continuing to care for children during out-of-home placement, the reinforcement of provider
techniques, or actually assessing for and selecting interventions for children who remained at home and were at risk for developmental disabilities, are examples of parent or caretaker participation in the intended model of care. These programs were also delivered within a family-centered atmosphere.

Martone et al. (1989) discuss several methods of engagement that promoted parental caretaking and involvement implemented in a residential treatment facility for adolescents. Parents were actively involved in treatment planning, were offered opportunities to interact with adolescents in activities geared toward family competence such as sports and birthday parties, and continued to serve in a caretaking role, along with the treatment team, while the child was living at the facility. Following this programmatic shift, lengths of stay were reduced from approximately 5.5 years to a little less than 1 year.

**TABLE 5 Programs that Have Evaluated the Use of Parent Mentors**

<table>
<thead>
<tr>
<th>Reference</th>
<th>Indicator</th>
<th>Outcome</th>
</tr>
</thead>
</table>
| Singer et al., 1999 | *Acceptance of family circumstances*  
*Perceived ability to cope*  
*Progress on presenting problems* | *Significantly greater increase in acceptance of family circumstances, perceived ability to cope and progress on presenting problems compared to control group* |
| Roman et al., 1995 | *Mother-child interactions*  
*Parental responsiveness*  
*Quality of home environment* | *Higher scores of mother-child interactions, parental responsiveness, quality of home environment, lower anxiety scores compared to control group* |
| Ireys, Sills, Kolodner, & Walsh, 1996  
Sullivan-Bolyai et al., 2004 | *Lower anxiety scores*  
*Parent mental health symptoms*  
*Overall concerns about managing disease*  
*Influence of disease on family*  
*Availability of community resources* | *Mothers exhibited decrease in mental health symptoms  
Mothers reported significantly less concerns, decreased negative influence of disease on family, greater availability of community resources compared to those who had not been linked to mentor* |
| Chernoff, Ireys, Devet, & Kim, 2002 | *Children’s psychosocial adjustment scores* | *Psychosocial adjustment scores of children whose parents had a mentor increased significantly compared to the control group* |
| Bickmann, Heflinger, Northup, Sonnichsen, & Schilling, 1998; Heflinger & Bickmann, 1997 | *Self-efficacy on obtaining mental health treatmentKnowledge of available services* | *Parents’ perceived self-efficacy on obtaining mental health treatment and knowledge of available services were significantly higher for those in intervention group than comparison group scores* |
Enhanced parent involvement can also have an impact on assessment and selection of effective interventions. Beyond the residential setting, parents of children at risk of language and behavior difficulties took part in a family-centered intervention (Chao et al., 2006). Parents in the intervention group kept a daily record of activities that related to their child’s health and development. They then selected strategies based on empirical evidence that would reduce any identified persistent problems. For issues that were not alleviated, parents followed information that had been provided to them on how to find the appropriate resource or service. Parents were also assigned to a “parent partner” who was a graduate student in special education or speech and language pathology. The purpose of the relationship was to jointly assess information collected on daily behavior and selected interventions. In a sample of 41 children ages 3 to 5 years old, children of parents receiving the intervention scored more favorably on standardized assessments of language development and behavior compared to children in the non-intervention group.

Parent involvement is a key component in the Positive Behavioral Interventions and Supports (PBIS) framework (OSEP Technical Assistance Center on Positive Behavioral Interventions & Supports, 2009). Parents take part in the assessment stage and build capacity for evidence-based approaches by reinforcing practices at home and in the community. PBIS acts as a guide for schools or other settings in implementing evidence-based practices and instructional pedagogies. Interventions are targeted at the individual, group, or universal (e.g., school-wide) level. PBIS reduces the use of negative disciplinary practices and instead incorporates a more meaningful approach through which the adult views each interaction with students as an opportunity to teach positive behaviors. Ongoing data collection and data analysis on selected interventions is a necessary component of PBIS. Implementation involves a school-wide team, an assessment of current procedures, identification of school-wide best practices and interventions at the group and individual levels that will be implemented, involvement of families in the development and delivery of new practices, and provision of family support. Results from an implementation study of PBIS in two day treatment programs and in a residential setting point to a significant decrease in safety holds and support room referrals (Kalke et al., 2007). While these outcomes are limited in terms of overall behavioral change, the application of this framework to residential settings, especially the idea of engaging parents in carrying out interventions, is noteworthy.

The practice of supporting parents or guardians in the provision of direct care follows guidelines for promoting family-driven care within residential settings (e.g., American Association of Children’s Residential Centers, 2006). The evidence found in the previous research suggests that the practice of having parents involved in the direct care of children while they are in residential care is an engagement activity that may prove beneficial in various residential settings.
B. Programs that Subscribe to System of Care Philosophy and the Wraparound Approach Produce Positive Outcomes.

According to Stroul and Friedman (1986), “a system of care is a comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with severe emotional disturbances and their families” (p. 3). The system of care philosophy purports that services should be family-driven, youth-guided, evidence-based, culturally and linguistically competent, and exhibit excellent clinical practice (Department of Health and Human Services, 2008). The wraparound approach is one practice commonly found in systems of care and directly involves the child and family in service planning to identify needs, strengths, and community supports (Center for Mental Health Services Division of Services and Systems Improvement, 1998). Child and family teams are the method of care planning used in wraparound approaches. While systems of care often aim to avoid the placement of children and youth in out-of-home care (Center for Mental Health Services Division of Services and Systems Improvement, 2005), some residential programs have implemented system of care principles and wraparound approaches to better align with the system of care philosophy.

The Sedgwick County Community Mental Health Center in Kansas employs a liaison who facilitates Community Based Services Team (CBST) meetings based on the wraparound model that includes feedback from people important in the youth’s life (J. Patterson, personal communication, April 26, 2008). This meeting takes place within seven days of the intake request. The program utilizes less restrictive services to the extent possible. If out-of-home care is necessary, shorter stays in care are utilized (e.g., a 90-day maximum stay may be initially approved, with a maximum of 60 additional days if requested later). The liaison assigned to the youth works with the youth while in care and following discharge. Treatment meetings occur every two weeks when possible and involve families. Preliminary data indicate that most youth are discharged at 90 days and are seldom in care past 150 days.

Other programs utilizing system of care principles have also found reductions in lengths of stay in care. St. Charles Youth and Family Services, Inc. in Wisconsin, a network provider for Wraparound Milwaukee, follows system of care principles (Building Bridges Initiative, 2008a). Residential treatment centers collaborate with child and family teams, and families drive treatment planning. A wide range of services are provided, including residential treatment, intensive day treatment (youth adjudicated as delinquent), day treatment, and care coordination. Lengths of stay in this program have decreased over time from 3 to 4 years in the 1960s and 1970s, to 1 year in the 1980s, to 3 to 4 months in 2007.
Damar Services in Indiana embraces the concept of wraparound by focusing on a continuum of care following residential services. Through their pilot program to extend residential treatment into more natural home settings in the client’s home community, transitional homes are leased that are close to the family and in the same school district (Building Bridges Initiative, 2008a). Trained personnel move with the child from residential care to the transitional home and remain with the child until discharge. Staff members welcome families and collaborate with them on handling various situations with the children. Children receiving services from Damar are generally concurrently enrolled in the Dawn Project, a care coordination program administered by Choices, Inc., a managed care entity. Outcomes in a study with over 100 youth in the Dawn Project included a statistically significant improvement in Child and Adolescent Functional Assessment Scale (Hodges, 1994) scores and an increase in the number of youth living in less restrictive settings at 12 months following enrollment (Anderson, Wright, Kooreman, Mohr, & Russell, 2003).

The system of care philosophy is also followed by the Eastern Residential Treatment Home (EARTH) (Pierpont & McGinty, 2004). Similar to the programs described previously, treatment includes weekly therapy sessions with parents and guardians and their participation in treatment plans and treatment goals. Other program components consist of continued relationships with educational systems, treatment staff, and the community during the transition phase. Results from a pilot study suggest that parent involvement was a factor in positive outcomes, although statistical data were not available. Families utilizing available social supports and mental health services also experienced a greater likelihood of behavioral progress and stability following discharge.

The system of care philosophy is also evident in residential facilities that follow a family-centered approach. The Reasonable Efforts to Permanency through Adoption and Reunification Endeavors (REPARE) program includes several family-centered components: parent education and skills training, presence of parents at the treatment facility, additional resources such as transportation and food to encourage participation, linking parents to community supports, and staff continuing to work with youth as they reintegrate into the community (Landsman et al., 2001). In a sample of 139 children ranging from 5 to 14 years of age, children in REPARE had significantly more in-person visits, fewer length-of-stay days, were significantly more likely to be discharged to their homes, and were more likely to remain in stable placements following treatment, as compared to children receiving standard treatment. Further, assignment to the REPARE group and shorter length of stay predicted a greater likelihood of achieving stability 12 months following discharge.

The Southern Oregon Adolescent Study and Treatment Center (SOASTC) piloted a program that provided intensive treatment and service
coordination with the focus on transition (Lieberman, 2006). The center coordinated overall treatment for the child, although flexible funding allowed for children to live at home, at the residential treatment center, or in other types of care, based on decisions made by the family and with the payer’s approval. The flexibility in funding also allowed for the service plan to include an array of community services based on the individual needs of the child. Wraparound services were provided to the entire family either at home or while the child was in the residential treatment facility. A discharge plan was also created that involved input from the family, treatment facility, and community. Compared to non-pilot children, children in the intensive treatment program were more likely to display improved clinical functioning, shorter lengths of stay in residential treatment or in acute treatment settings, and were more likely to be discharged to their families’ or relatives’ homes. Children in the pilot program were also less likely to be readmitted to treatment 30 and 180 days following discharge. These outcomes further support system of care philosophy, particularly the wraparound approach and attention to community transitions.

The Carolinas Project specifically focused on improving family-centered care in a number of North and South Carolina residential facilities (Alwon et al., 2000). Implementation involved several steps such as developing family-centered curricula, creating agency action plans, distributing a newsletter to communicate promising practices, coordinating a conference to bring program implementers together, collaborating between public and private providers, developing core training curricula, and the formation of task groups and family focused forums on family-centered practices. As part of the design, a schema of family-centered care included six steps: (1) Promoting a partnership between staff and families; (2) Identifying family and community strengths while acknowledging challenges; (3) Emphasizing change through working together; (4) Celebrating accomplishments, strengths, and change; (5) Realizing the families’ ability to cope and separate from staff; and (6) Reflection. Results indicated significant increases in the availability of family-specific services, parent involvement, and parent decision making. These outcomes suggest that family-centered care and system of care philosophy, especially working with the family and identifying family and community strengths, are strategies that contribute to increased family involvement in the treatment or care of children.

Elements of the wraparound approach and system of care philosophy are also apparent in a few residential psychiatric treatment settings that reported positive outcomes. A short-term intensive psychiatric setting for adolescents included group and individual therapy, a focus on transition back to the community, and the use of a social worker to provide family therapy and participate in all aspects of the treatment process (Leichtman et al., 2001). Statistically and clinically significant improvements on behavioral and mental health assessments resulted within 12 months following discharge.
for a sample of 123 youth. Shorter stays and sustained family outcomes for adolescents were also obtained in an inpatient psychiatric setting in which parents were empowered by staff to identify and promote behaviors that would be expected upon a return home, create strategies to elicit behavioral change for the youth, and implement the treatment plan (Byalin, 1990). Further, reductions in length of stay from 14 to 9 months were found in an evaluation of an enhanced psychiatric residential program for children 5 to 12 years of age. In this program, the enhancements included a 6-week family orientation, parent participation in the educational programs, intensive family therapy during and following residential stay, family advocacy supports, and support of the family in the natural environment (Knecht & Hargrave, 2002).

Residential care has often been referred to as the placement of last resort (Frensch & Cameron, 2002; Little, Kohm, & Thompson, 2005; Whittaker, 2000), yet a necessity in some circumstances (Ainsworth & Hansen, 2005; Stroul, 1996; Stroul & Friedman, 1996). It is not surprising, then, that placement in out-of-home care continues to be a trend for youth participating in systems of care (Farmer, Mustillo, Burns, & Holden, 2008). The aforementioned research points to the evidence behind family-centered practices that apply a wraparound strategy or system of care principles in the residential setting. With the increasing integration of community-based and out-of-home care services for children and families, it makes sense to incorporate similar principles and practices across both of these settings. McCurdy and McIntyre (2004) also recommend a stop-gap model where youth participate in short and focused residential stays while concurrently preparing for a sustained successful transition to the home and community environments.

Some of these approaches were recognized by the Department of Health and Human Services, Administration for Children and Families (ACF) in their child and family services reviews. The ACF (2009) cited two programs that utilize coordinated systems of care approaches as promising child welfare practices. One is the Dawn Project, which was previously mentioned, and the other is the Family Based Services Initiative in Massachusetts, where community and residential providers are working together to establish a continuum of care, particularly for transition or diversion. Both programs contract with several agencies to maintain an array of services and coordination of care (ACF, 2009), which suggests that purchase of service agreements may support communities in their ability to provide a comprehensive service array to meet the multiple and changing needs of children, youth, and families.

C. THE OUTCOMES OF FAMILY ENGAGEMENT STRATEGIES OR FAMILY-CENTERED PRACTICES ARE MEDIATED OR MODERATED BY OTHER VARIABLES.

In a review of family-centered research studies, primarily for children with developmental disabilities and their families, Dempsey and Keen (2008)
M. L. Affronti and J. Levison-Johnson found that the following variables moderated, or served as an influential factor, in the effect of family-centered practices on outcomes: parent demographics and characteristics such as employment status and education, staff training, child's age, parent involvement with advocacy groups, parent self-efficacy and supports, staff characteristics such as experience and training, child behavior problems, and level of disability. Further, the majority of dependent variables focused on parent outcomes such as parent satisfaction, well-being, or empowerment. This review highlights the need for more research on the child outcomes that may be related to family engagement strategies. It also defines the critical need for programs to incorporate assessments that will capture mediating or moderating relationships in family engagement outcomes studies.

Research also emphasizes the relationship between family functioning and outcomes for children in residential care. Specifically, significant positive correlations were found between family functioning at discharge and both family therapy attendance and parent contacts (phone calls alone or phone calls and visits to the facility or therapeutic visits) in a study with 89 youth in a psychiatric residential facility (Lakin, Brambila, & Sigda, 2004). Scores of family functioning were also significantly higher for children who did not return to the facility following discharge. It is unclear, however, if family functioning was a product of participation in the therapeutic process or if the level of functioning was preexistent. Sunseri (2004) found that higher levels of family functioning at intake for almost 9,000 youth in residential treatment centers were correlated with program completion.

Gavidia-Payne and Stoneman (1997) found that family functioning influenced maternal involvement in an early intervention program through the mother’s coping strategies; thus, as mothers experience higher levels of family functioning, they may cope better and may be more likely to stay active in programs. A similar pattern existed for fathers. Taken together, these studies suggest that more research is necessary to determine the relationship between family functioning/family engagement and treatment outcomes and that conducting assessments of family functioning may be important during initial stages of family-centered program implementation.

The value of family contact, communication, and partnership between parents and staff, and an active decision-making role for parents in regard to their child’s care is also supported by research that explores family and provider perspectives.

Qualitative and quantitative research supports the notion that families, community partners, and staff perceive that family involvement is a necessary component in residential care. In a study using self-report questionnaires, adolescents and mental health workers perceived family involvement, in the form of telephone contacts, letters, and visits, as a valuable aspect of therapeutic
care in a residential treatment setting (Abraham, Reddy, & Furr, 2000). Qualitative interviews with 17 parents of youth in a Midwest residential treatment center revealed that parents were mainly interested in being treated as experts and partners (Demmitt & Joanning, 1998). Many also desired more information about their children’s daily behaviors, more involvement in home visits, the ability to provide input on their children’s treatment goals, and more opportunities for parent support groups; it was also important to them that staff try to get to know them as people.

Individuals working in the child welfare system, such as family court judges, children’s lawyers, social workers, and advocates, expressed concern that staff may assume families are not interested in participating in their child’s treatment, and that physical distance between centers and families’ homes may hinder engagement (Freundlich & Avery, 2005). However, phone therapy was an option for 47 parents of children in a residential placement due to the geographical distance (Springer & Stahmann, 1998). Results indicated that the number of sessions of phone therapy with therapists and adolescents was positively related with parents’ perceptions of improved family communication. Thus, phone therapy may bridge the gap for parents whose children do not live near an appropriate residential facility.

Although there is little empirical information supporting the effectiveness of family participation in agency boards or governance, advocates of family-centered and family-driven care view these activities as important (AACRC, 2006; Building Bridges Between Residential and Community Based Service Delivery Providers, Families, and Youth, 2006). Results from one study identify reasons why some parents participate on boards of directors. Caretakers who were members of a collaborative board for a university-community partnership for an HIV prevention/adolescent mental health project study reported social support and learning opportunities as the main reasons for board participation (McKay, Pinto, Bannon, & Guilamo-Ramos, 2007). Parents also suggested that involvement on other boards and knowing someone on a board encouraged participants to join and remain on the board.

Family preferences are critical to the development of evidence-based practices (AACRC, 2008; American Psychological Association, 2005; Lieberman et al., 2009) and should be considered in conjunction with other quantitative research mentioned in this paper. The aforementioned studies captured family and staff perceptions of how families might be involved in the care or treatment of their children while in residential placement. Family contact, collaboration between parents and staff, and an active role for parents in decision-making in their child’s care were perceived as useful or desired components of family-driven and family-centered care in the previous research. These perceptions further support the notion that there should be a framework for family-driven and family-centered care in residential facilities.
Research Question 2: What family engagement strategies are most essential and have the most power in producing the desired effect(s)?

Much of the research in family engagement relates to settings outside of residential treatment, but may be generalizable to residential care. There are, however, some findings specific to residential care, which are also included. There are three main findings for this question:

- Programs that use strategies to reduce initial barriers to engagement result in positive outcomes.
- Programs for youth that include parenting education/treatment or family therapy reflect positive outcomes.
- Incorporating parent mentors into programs is a promising strategy to engage families and move toward becoming family-driven.

A. Programs That Use Strategies to Reduce Initial Barriers to Engagement Result in Positive Outcomes.

A number of programs offer specific techniques or interventions geared toward facilitating engagement. These programs have been researched in other settings, but may be replicable within residential programs. Many of these services employ strategies to engage families during the first few contacts and follow with additional components such as family therapy or parenting education. Specifically, a core component of the Adolescent Transitions Program (ATP), a program that targets adolescent depressive symptoms, is the Family Check-Up (FCU; Dishion & Kavanagh, 2003), which is based on motivational interviewing (Miller & Rollnick, 2002). The FCU aims to engage parents during three sessions that include exploring parent concerns, readiness for change, potential participation in family management strategies, and assessing children’s behaviors (Dishion, Kavanagh, Schneiger, Nelson, & Kaufman, 2002). Parents may then be offered the ATP parenting component, a 12-session curriculum focusing on child and parent engagement, behavioral management and positive reinforcement, and improved family interactions. An additional ATP module is available to youth in the program and includes several methods of social, educational, and physical skill-building. Further, family resource centers are located in ATP schools that provide concrete resources such as books and in-person and telephone opportunities for parents to discuss concerns and feedback about their children with a parent consultant. Connell and Dishion (2008) found that compared to a control group of youth, depressive symptoms did not significantly increase in a 3-year period for a sample of 106 high-risk youth recruited as sixth graders. In another ATP study, children in families who elected to receive the FCU portion of the ATP experienced less increase in substance use and behavioral issues from 11 to 17 years of age.
compared to control groups (Connell et al., 2007). Additionally, children whose parents received the FCU exhibited a decrease in the likelihood for arrest and substance use diagnoses at 18 years of age. Stormshak, Dishion, Light, and Yasui (2005) also studied the sole effects of the family resource center component mentioned previously on youth outcomes. They found that while implementation and use varied over time among schools, growth in youth problem behaviors were significantly reduced for schools utilizing the family resource centers.

Brief Strategic Family Therapy, a model that can be applied to adolescents with behavior problems or substance abuse issues (Coatsworth, Szapocznik, Kurtines, & Santisteban, 1997; Szapocznik & Williams, 2000), utilizes the Strategic Structural Engagement strategy to engage families (SSSE; Szapocznik & Kurtines, 1989; Szapocznik, Perez-Vidal, Hervis, Brickman, & Kurtines, 1990). The procedures allow the treatment provider to identify barriers within family patterns that may prevent engagement in treatment as well as the best approach to communicating the usefulness of therapy. In randomized trials, this approach was deemed more effective than other models in engaging and retaining families (Santisteban, Szapocznik, Perez-Vidal, Kurtines, Murray, & LaPerriere, 1996; Szapocznik et al., 1988). Following engagement, Brief Strategic Family Therapy aims to identify and restructure maladaptive family patterns for healthier and more effective relationships (Coatsworth, Santisteban, McBride, & Szapocznik, 2001). Brief Strategic Family Therapy has also exhibited higher rates of attendance and retention compared to a community control et al., 2001). This approach has been tested primarily with African-American or Hispanic populations (Szapocznik & Williams, 2000). Similarly, Functional Family Therapy (FFT) is applied to adolescents with behavioral issues, aims to produce results in a short time-frame, has been tested with several populations with mixed backgrounds, and has documented evidence in long-term and independently replicated studies (Sexton & Alexander, 2002). FFT incorporates an initial engagement strategy that reframes issues up front to minimize resistance, build trust, and generate hope.

A targeted approach to improving engagement was explored with parents of children utilizing outpatient mental health services in a multisite study (McKay et al., 2004). An engagement interview for first telephone or in-person contact was implemented that focused on: a) reducing barriers to service delivery at the agency; and b) reducing barriers at the environmental level by discussing stigma, mistrust, potential negative responses from other family members such as blame, and problem-solving on concrete barriers (e.g., transportation, race or cultural issues, poverty, and safety). Following the interview, family and child attendance rates from first to second contact ranged from 60% to 100% across sites compared to the 50% show rate in comparable populations reported by the authors. It is important to note that staff took part in a one-day training that specifically emphasized engagement
skills and included role plays, group work and a video of parents who discuss perspectives on engagement. Engagement teams, which were comprised of intake workers, clinical and administrative staff, and supervisors, met monthly to discuss implementation and continuous quality improvement.

An evaluation of the Alternative School Program (AS), a program that serves students considered to be persistently disruptive in order to prevent dropout and improve school safety, was conducted to compare their traditional program to a model utilizing an additional family involvement approach (Aeby et al., 1999). Although not as in-depth as strategies in previously mentioned programs, an intake meeting with parents and the student was employed that can be viewed as an initial engagement strategy. Families of students considered to be persistently disruptive were offered the following intervention components: (a) an intake interview during which the family identified strengths, barriers, and opportunities for the student to achieve educational success; (b) meetings with staff at least six times while the student attended the program; (c) individual and family therapy; (d) phone conferences with the school and other agencies participating in the youth’s care, such as the court system; (e) at least three family meetings for decision making on the student’s educational program; (f) family-teacher conferences; (g) additional meetings to communicate on the student’s progress, many of which took place with the assistant principal; and (h) meetings to discuss transition to another academic setting. Youth outcomes were assessed for 210 students receiving AS with family involvement (experimental group) or without family involvement (control group). Students in the experimental group displayed significantly more favorable locus of control scores at discharge (i.e., they felt more responsible for their behaviors), significantly higher grades than the control group at discharge, higher attendance rates during the program and at discharge, and lower rates of dropout at 150 days following discharge. However, scores on measures of self-esteem and depression did not differ between the two groups at baseline or at the time of return to the home school. While specific measures of engagement were not employed, favorable student outcomes suggest that a multidimensional approach to family involvement from the onset of care and throughout the program is necessary. This approach may be an option for school-based residential settings interested in implementing a family-centered approach.

While the above engagement strategies have not been evaluated in residential settings, strong evidence exists that some of these programs produce positive outcomes in children’s behaviors and family functioning. Shirk (2004) proposed that empirically validated engagement strategies within research-based programs may be the ideal combination in child and adolescent treatment. A few of the aforementioned programs (e.g., Brief Strategic Family Therapy) represent this level of validity and pose an opportunity for further evaluation within residential settings.
B. Programs for Youth that Include Parenting Education/Treatment or Family Therapy Reflect Positive Outcomes.

A number of programs discussed in the previous section incorporate parenting education or family therapy and strategies to reduce barriers to treatment (e.g., Adolescent Transitions Program, Brief Strategic Family Therapy, and Functional Family Therapy). The programs in this section also provide parenting education or treatment, but do not specifically cite strategies that reduce barriers to treatment. Positive Attitudes toward Learning in School (PALS), is geared toward increasing services for children with Disruptive Behavior Disorder in urban elementary schools in high poverty areas and combines parent education and a classroom-based program (Atkins et al., 2006). Services include contact every two weeks through home visits or parent groups that focus on supporting children in education, behavior management, and discussions of other parenting-related issues. Parent groups are co-facilitated by a clinician and parent advocate. Teachers also implement specialized strategies in the classroom and are encouraged to communicate with parents. Over 80% of families in the program remained in services for 12 months, a significantly higher rate than families in the comparison group who were referred to a neighborhood mental health clinic. Participation in PALS correlated with positive changes in children's behavior as well as improvements in children's academic performance.

An increased likelihood of family reunification was evident for families whose parents participated in a program that combined parent education and parent involvement in residential treatment, compared to parents who participated only in parent education or only in parent involvement (Carlo, 1993). In a follow-up study, 78% were still reunified compared to 52% in the comparison intervention (Carlo & Shennum, 1989). Thus, a multidimensional approach to family involvement appears to be beneficial.

Family therapy participation significantly predicted discharge to a less restrictive setting in a review of 130 records of males utilizing a residential treatment facility serving youth with challenging behaviors (Stage, 1999). In a randomly selected sample of 150 charts of young adults served by a community mental health agency for runaway and homeless youth, which included a residential treatment center, Gorske et al. (2003) found that when families participated in therapy, the primary clinician was significantly more likely to rate treatment outcomes as successful at discharge. In other research, the presence of home visits predicted completion of treatment for 313 children and adolescents placed in a residential treatment facility (Sunseri, 2001), a finding that solidifies the notion that family contact is essential whenever possible for children in care.
C. Incorporating parent mentors into programs is a promising strategy to engage families and move toward becoming family-centered.

Involving or employing parents whose child had experienced residential care is a recommended strategy for family-centered or family-driven models of care (AACRC, 2006; Building Bridges Between Residential and Community Based Service Delivery Providers, Families, and Youth, 2006; Spencer & Powell, 2000). Much of the research on this model has occurred in the medical or health fields, but offers promising results. For example, parents of children with disabilities that participated in a program that matched them to a supportive mentor who also was a parent of a child with a disability exhibited a significantly greater increase in acceptance of their family circumstances and perceived ability to cope and achieve progress on presenting problems, compared to the control group (Singer et al., 1999).

Results from other studies further support the evidence behind the use of the parent mentor model in medical settings. The results of one study reported higher scores of mother-child interactions, parental responsiveness, quality of home environment, and lower anxiety scores in comparison to a control group for mothers of pre-term infants (Singer et al., 1999). Mothers of children with juvenile rheumatoid arthritis also indicated a greater decrease in parental mental health symptoms after receiving services from a parent mentor (Ireys et al., 1996). Mothers of children diagnosed with Type 1 diabetes reported significantly less worries regarding disease management, a decreased negative influence of the disease on the family, and a greater availability of community resources compared to those who had not been linked to a parent mentor (Sullivan-Bolyai et al., 2004). Further, in a randomized control trial, mothers of children diagnosed with diabetes or other health conditions such as asthma were connected with parent mentors and child life specialists and received other supports. Children’s mean psychosocial adjustment scores over a 15-month period in an intervention group increased significantly compared to the control group (Chernoff, Ireys, Devet, and Kim, 2002).

One study with documented outcomes related to parent mentoring was located in a mental health setting (Bickmann, Heflinger, Northrup, Sonnichsen, & Schilling, 1998; Heflinger & Bickmann, 1997). In this program, professionals and parents of children who had experienced mental health challenges co-facilitated workshops that provided education on mental health services and suggestions for navigating the system. While children’s outcomes, such as mental health status, did not significantly differ between treatment and comparison groups a year after the training, parents’ perceived self-efficacy on obtaining mental health treatment and knowledge of available services were significantly higher for those in the intervention group compared to those in the comparison group (Heflinger & Bickman, 1997).
The differences, if any, between parents that have had a child with a medical condition compared to parents with children in residential treatment, would be an important consideration for the application of the parent mentor approach to the residential settings. To date, the strategy of assigning a mentor whose child has experienced residential care to another parent with a child currently in care has not been researched in residential care; however, the extensive research in the medical field suggests that this practice should be considered in other human services settings such as residential facilities. Further, residential treatment facilities already use this model (e.g., Hathaway-Sycamores) and this approach is recommended by groups that endorse family-driven care (e.g., AACRC, 2006; Building Bridges Between Residential and Community Based Service Delivery Providers, Families, and Youth, 2006).

Research Question 3: What other emerging and innovative practices exist in residential care?

There was one main finding to this question:

- Emerging and innovative practices in residential care follow family-driven and system of care principles and reflect similar trends found in studies with documented outcomes

Emerging and innovative practices in residential care follow family-centered and system of care principles and reflect similar trends found in studies with documented outcomes.

Several innovative or emerging programs in residential care utilize family-driven principles and may be helpful when considering a change-based initiative in a residential setting. While results from outcomes studies are not available for many of these settings, these programs represent the general movement toward family-centered services and system of care principles. For example, Hathaway-Sycamores Child and Family Services in California has implemented a family involvement framework to increase and formalize the agency’s commitment to family-driven care. Services are funded through California’s first Title IV-E Waiver. Twenty-seven full-time Parent Partners are employed in the agency’s departments. Parent involvement is common practice in all services. A youth coordinator and five youth advocates have also been hired (Building Bridges, 2008a).

Trillium Family Services in Oregon encouraged successful transitions by providing in-home services as children return from residential care to home (Building Bridges Initiative, 2008a). One of their overall fiscal goals was to contract with private payers to use residential treatment for stabilization
and less for ongoing care, which mirrored the philosophy that children should be maintained in the home environments whenever possible. Trillium has also reduced restraint and seclusion, has implemented trauma-informed practices, and has worked with children to identify personal strategies for regrouping during stressful time. During their transformation process to a new mode of services delivery, Trillium consulted with and received supervision from evidence-based practice experts and collaborated with other agencies similarly engaged in evidence-based practice implementation. They also created a system of monitoring and accountability for their community providers.

The Village Network in Ohio is a sex offender unit designed to shorten lengths of stay by providing a high level of intensity to treatment (J. Miller and J. McCafferty personal communication, March 2008). The goal is to increase the stability for long-term permanent custody. Treatment hours per day are maximized by incorporating treatment into everyday activities such as recreation time and meals. Supervisory approval is required if family treatment is not going to occur. Staff also works with youth beyond residential care, which encourages seamless transition back to the community. In order to increase parent participation, children encourage their parents to become involved in their care. This program, along with Hathaway-Sycamores, and Trillium, highlights the growing trend of implementing system of care principles, the wraparound approach, and employing parent partners in residential settings.

These models or approaches continue to build the case that family-centered practices offer important opportunities for residential treatment. Specifically, a focus on direct family involvement in the treatment milieu and transition planning are common threads among several of the emerging models. These and other themes were used to suggest a series of recommendations based on the literature explored in this paper, which will be presented in the following sections.

RECOMMENDATIONS

Specific recommendations emerged from the synthesis of the literature. These recommendations align with current policy and advocacy efforts surrounding family-centered and family-driven care models, which will be presented as well. It is imperative to note that the dearth of research on family engagement strategies and family-centered models of care does not allow for precise recommendations to be made with respect to individual engagement activities. Rather, broader recommendations are made for service delivery options or program models.
1. **Involve parents or guardians in the active delivery of care for their children.**

   Research (Chao et al., 2006; Kalke et al., 2007; Martone et al., 1989) suggests that the practice of parents playing an active role in the delivery of care for their children may be an effective strategy for residential care. Programs can train parents in effective intervention practices, have parents implement these strategies within the treatment milieu, and support parents in reinforcing these behaviors at home. This kind of collaboration with parents is also backed by the Building Bridges Initiative (2008b) in their performance guidelines and indicators matrix and the AACRC (2006) in their position paper on family-driven care.

2. **Utilize system of care principles, particularly the wraparound approach and focused attention on transition services, as a mechanism to move toward implementation of family-centered strategies.**

   Systems of care and family-centered approaches such as the wraparound approach and child and family team process (e.g., Sedgwick County Community Mental Health Center, and St. Charles Youth and Family Services) are promising methods of increasing family-centered practice in a residential setting. These efforts, coupled with focused attention on transition (e.g., Damar Services, Knecht & Hargrave, 2002; Landsman et al., 2001; Leichtman et al., 2001; Pierpont & McGinty, 2004) reflect the applied use of system care principles and approaches in residential facilities or treatment centers. Child and family teams are also recommended by AACRC and in the Building Bridges performance guidelines (AACRC, 2006; Building Bridges Initiative, 2008b).

3. **When implementing family engagement strategies or family-centered interventions, utilize assessments that adequately identify factors which may alter the strategies’ or interventions’ effect on outcomes.**

   The literature identified several factors that may moderate the effect of family engagement strategies (e.g., Dempsey & Keen, 2008). In order to truly learn which family engagement or family-driven strategies are effective, it will be necessary to evaluate the direct connection between strategies and outcomes. Standardized assessments that can identify important variables such as the influence of caretaker supports or caretaker demographic characteristics can assist agencies in achieving long-term effectiveness with regard to engagement strategies. Other influential variables may be uncovered that are unique to certain populations, which supports a culturally competent approach to implementation.

4. **Implement evidence-based strategies that reduce initial barriers to engagement.**

   Engagement strategies have been incorporated as a component of evidence-based programs and are the first step in care delivery (Connell, 2007; Szapocznik & Williams, 2000). Residential facilities should explore the application of these approaches to their settings. At the very least,
residential centers can begin to explicitly explore barriers to treatment and program success with families, which was a strategy utilized in several settings (Aeby et al., 1999; Connell et al., 2007; McKay et al., 2004; Szapocznik & Williams, 2000).

5. **Offer family therapy and parenting education to the extent possible.**

Family therapy is a common element among several programs mentioned in this paper and has been linked with positive results in residential treatment facilities (e.g., Gorske et al., 2003; Stage, 1999). Residential centers will need to select family therapy approaches and parenting skills educational opportunities based on the needs of their specific population.

6. **Integrate parent mentors into practice settings who have previously had a child in residential care.**

The use of parent mentors who have experienced similar challenges has been linked to a number of positive parent outcomes and a few child outcomes mainly in the medical literature (e.g., Ireys, 1996). Some residential facilities have embraced this practice (e.g., Hathaway-Sycamores). Also, the AACRC (2006) and Building Bridges Initiative (2006) recommend hiring or involving parents who have had children in residential treatment. The application of this practice beyond the health or medical setting is in need of further exploration, but appears to be a promising practice that has begun to be used in residential settings.

The findings from the three previous questions yielded specific recommendations that residential facilities may want to consider in efforts to become more family-centered. Considering the inherent challenges with implementation of practice change initiatives, additional research was conducted in order for residential facilities to begin to envision methods through which recommendations may be put into practice. This research is reflected in the section that follows.

Research Question 4: What are the critical steps needed to promote a culture and practice change initiative within residential care facilities?

Several strategies to assist in a change process were located. A recommended initial step that assists organizations in matching their philosophies and values with intended goals will be discussed first. A framework that provides steps for implementing and evaluating program changes and has been associated with improved outcomes in prevention programs, but has broad applicability to other initiatives, will then be presented. Other specific organizational change strategies will be included in the steps where they appear to fit.
A. DEVELOPING A THEORY OF CHANGE AND LOGIC MODEL SERVES AS AN IMPORTANT FOUNDATION FOR PRACTICE CHANGE AND TRANSFORMATION EFFORTS.

The theory of change and logic model is a process that has been recommended as a tool for evidence-based practices implementation and system transformation efforts, particularly in systems of care (Hernandez & Hodges, 2005). A theory of change is essentially the articulation of what an identified group of stakeholders believe is needed for a specific population of focus and a set of strategies that are designed to meet those needs. The process results in a clear sense of the intended overarching goals for a particular initiative (vision) and also the values which underlie these goals. In this way, it often serves as a critical unifying tool when attempting to implement practice change initiatives by ensuring alignment across key constituencies. The logic model provides the framework to graphically represent the theory of change by identifying and linking the population of focus, strengths and resources, outcomes, and the proposed strategies to achieve defined outcomes. Careful attention to development of a theory of change and logic model will yield a clearly defined roadmap which informs technical assistance needs, continuous quality improvement efforts, and ultimately sustainability. Through this process, a shared sense of what is intended is realized which serves as an important foundation for change initiatives.

Critical to the success of the implementation of family-centered practices will be the focused and intentional activities aimed at inclusion of family members in the process. The concept of family-driven requires that families are involved in designing, implementing, and evaluating programs (National Federation of Families for Children’s Mental Health, 2008). Residential centers seeking to engage in program redesign will need to decide how to invite families to the table to be a part of the process, and will also need to create strategies which allow families to feel that they are equal partners in these efforts. Including families during the theory of change and logic model process and in all subsequent steps is ideal.

B. THE GETTING TO OUTCOMES FRAMEWORK AND PRINCIPLES OF EMPOWERMENT EVALUATION ALIGN WITH THE PRINCIPLES OF FAMILY-CENTERED CARE AND MAY PROVIDE A USEFUL FRAMEWORK FOR IMPLEMENTATION OF FAMILY ENGAGEMENT PRACTICES.

The Getting to Outcomes (GTO) framework (Fetterman & Wandersman, 2005) defines several practical steps which fall into three broad categories (planning, evaluation, and sustainability) to consider when implementing and evaluating outcome-based programs. Based on the principles of empowerment evaluation which include: democratic participation, accountability, capacity building, inclusion, community ownership, and social justice (Chinman et al., 2004), GTO offers a straightforward process for examining key factors related to implementation that ultimately impact success. While the Getting
to Outcomes framework has demonstrated success in prevention programs, it also has broad applicability to other initiatives (Wiseman et al., 2007). Currently, the framework is being applied to systems of care and other transformation initiatives due in large part to its proven success in supporting information-based decision-making in other arenas.

Considering the alignment between empowerment evaluation principles and those that underlie the concept of family-driven, suggested strategies for implementation will be presented using the GTO framework. Other recommendations made by researchers on evidence-based practice implementation and reports from residential facilities that have undergone major program transformation will be integrated into the discussion. Considerations unique to the implementation of family engagement strategies will also be included.

The following offers a high-level summary of the 10 GTO steps with specific application to practice change initiatives.

1. **What are the underlying needs and conditions in the community?**
   This question essentially aims to articulate the why or rationale of the practice change initiative. It encourages key stakeholders to identify the impetus for the proposed changes (needs) and the strengths or assets (resources) that can be mobilized toward implementation. To clearly define what specific needs are being addressed is critical to the selection of proper practices and implementation strategies.

2. **What are the goals, populations of focus, and objectives (i.e., desired outcomes) for your initiative?**
   The ability to identify who the intended practice change is for, and what it is attempting to address, is a critical component. Delineation of the desired outcomes will assist in the identification of which best practices, such as those identified in the aforementioned recommendations, should be considered for implementation. Residential centers may also want to consider if they are interested in using engagement as a strategy (e.g., empowering families), a result (e.g., number of family therapy sessions), or an adjunctive component (e.g., involving families on boards).

3. **What evidence-based models and best practice programs can be useful in reaching the goals?**
   The research presented in this paper offers several elements of family-centered practice and engagement indicating evidence in populations with varying degrees of similarity to residential care populations. The application of these approaches may or may not be suitable to different residential care environments. As a collaborative effort, several residential facilities may want to consider a few general strategies such as initial engagement steps or a parenting education component, and then others that are geared toward the unique populations at each center.
4. *What actions need to be taken so the selected program fits the community context?*

Critical to this stage are the assessment of cultural and linguistic needs and agency context and the ability of the program to respond to these varying needs. Soliciting input from board members, youth, families, community members, and staff is an important step to determine if there is alignment between the strategies and program goals. Checking in with these same stakeholders will also be an important step to determine if there is agreement that the program will be a fit. Acceptability of the program to staff and families, the ability of the program to meet the family's needs, staff motivation, past experiences with evidence-based programs, organizational support, and the influence of the program on outcomes were found to be important components for the implementation of an evidence-based practice in a child welfare setting (Aarons & Palinkas, 2007) and are also important components when determining fit.

5. *What organizational capacities are needed to implement the plan?*

Hayes (2005) suggests that leadership, vision and mission, board, financial stability, culture, technical capabilities, training needs, readiness to accept resistance, and the ability to include several levels of staff are some of the necessary areas that should be assessed when considering implementation of evidence-based practices. There is evidence that higher needs and stressors, limited resources, and lower ratings on staff characteristics and organizational climate predict the likeliness that an organization will be ready to implement a change strategy (Courtney, Joe, Rowan-Szal, & Simpson, 2007). In their review, Hemmelgarn, Glisson, and James (2006) point to the evidence that organizational factors, such as culture and climate, are a part of the success of evidence-based program implementation. Further, higher ratings of organizational functioning (Greener, Joe, Simpson, Rowan-Szal, & Lehman, 2007) and other organizational issues such as climate have been correlated with higher ratings of client engagement in treatment (Broome, Flynn, Knight, & Simpson, 2007). It has also been found that children’s psychosocial functioning significantly increased when served by more positive agencies (Glisson & Hemmelgarn, 1998). Similar findings resulted from a later study in which children in child welfare and juvenile justice systems were more likely to receive mental health care when their case manager worked in a more constructive culture described as one with positive and mutual relationships and a focus on professional growth (Glisson & Green, 2006). This research suggests that an assessment of organizational readiness on several levels will be necessary for implementation.

The Organizational Readiness for Change scale (Lehman et al., 2002) assesses a variety of program and staffing needs such as resources, training, staff characteristics, and organizational climate, all of which are factors that may contribute to a successful organizational transformation.
Originally tested with drug treatment providers in adult settings (Lehman et al.), the validity of this measure was supported in a study assessing its applicability with adolescent treatment providers (Saldana, Chapman, Henggeler, & Rowland, 2007). This scale, along with a survey of Program Training Needs (PTN; Rowan-Szal et al., 2007), the Client Evaluation of Self and Treatment (Joe, Broome, Rowan-Szal, & Simpson, 2002), and workshop evaluation forms was also used in a study with over 200 counselors who attended a training on the therapeutic alliance with clients in substance abuse treatment programs (Simpson et al., 2007). Results from the study indicated that past training experiences were related to use of training content after completion of the workshop. The PTN measures domains of staff training such as content and strategy preferences, barriers, and satisfaction, and although primarily tested with substance abuse treatment providers, is another tool that agencies may want to consider to assess training needs prior to or as part of a change strategy (Rowan-Szal et al., 2007). A measurement of Organizational Social Context, which has recently been developed using a nationwide sample of adolescent mental health providers, can provide an organizational profile of culture, climate, and work attitudes that may influence the adoption of evidence-based practices and overall success of services delivery (Glisson et al., 2008). As noted previously, a thoughtful theory of change and logic model process can also support the development of a clearly articulated change strategy and provide a roadmap for change initiatives (Hernandez & Hodges, 2005).

6. What is the plan for this program?

The implementation plan may include the creation of a workgroup or task force charged with carrying out the actual strategies, identifying champions who will take the lead in overseeing the plan, selecting specific components of the evidence-based strategy, creating timelines, determining the necessary training needs, and piloting the program. Training, coaching, and mentoring will likely be crucial factors in the implementation of engagement strategies. For example, in their shift to an individualized service planning model, one residential program decided it was necessary to emphasize a family-centered and community-based focus in recruitment, orientation, and overall training, which included retraining all staff and selecting current staff to become future trainers (Manner & Miles, 2008). They also involved families in training and hiring new staff, and hired parent partners. Family Centered Support Centers were created to provide skill-building activities for parents.

Leadership support, commitment to engagement principles, working toward reducing road blocks such as frustration with new principles, and a shift in perspectives toward clients, are recommended for agencies implementing trainings on engagement strategies (McKay et al., 2004). Residential programs may select from a variety of engagement tools,
some of which may require training by the developer of the strategy or program. If the program or strategy is evidence-based, then residential facilities may need to have certified trainers conduct the intensive training (e.g., Brief Strategic Family Therapy or Functional Family Therapy). Training logistics such as length, follow-up, and content will depend on the strategy. For example, a training on a first contact engagement strategy with families in the mental health system is 8 hours in length and includes, in addition to engagement techniques, a presentation of barriers to treatment, empirically validated engagement strategies, methods for cultural sensitivity, stories from families who have sought treatment, role plays and interactive participation, and a description of the continuous quality improvement cycle (McKay et al., 2004).

If parents are hired or will serve in a voluntary role, they will likely require training as well. Tapestry, a wraparound program in San Diego with a particular focus on access to services for families of color, utilized the Parent Partners (Becker, 2003) training to prepare parents whose children have had mental and emotional challenges and to work with other parents in similar situations. This training may serve as a guide or an initial resource in thinking about the skills that parents will need to work with other parents in the residential system (Becker & Kennedy, 2003).

Participating organizations may want to consider a learning collaborative approach to support implementation. As part of the implementation process of an engagement strategy with the goal of enhancing mental health service use for urban youth and families, 15 mental health agencies participated in a learning collaborative approach that brought together implementation teams consisting of supervisors, services staff, and administrative personnel (Cavaleri et al., 2006). Three learning sessions provided the training on engagement strategy and discussed methods of change and implementation. Teams also added additional service components as identified by the agency. The average rate of attendance at intake appointments increased 14% during the months of learning collaborative implementation and then 18% at the end of the collaborative. In addition, the percentage of appointments kept for ongoing attendance increased by 4% during the time of the collaborative and then an additional 1% at the end of the learning collaborative. Termed the “Learning and Innovation Community,” this approach has also been used in many medical and human services settings to implement and evaluate change strategies (Institute for Healthcare Improvement, 2008).

Residential centers may want to consider Availability, Responsiveness, and Continuity (ARC), an intervention to guide organizations in the implementation of effective children’s services (Glisson, 2002; Glisson & Schoenwald, 2005; Glisson, Dukes, & Green, 2006), as part of their plan. According to Glisson et al. (2006), the effectiveness principles for ARC were based on a model for public service organizations (Osborne & Gaebler,
M. L. Affronti and J. Levison-Johnson

The five principles include a focus on mission, results, improvement, building and supporting relationships among all systems involved in the service, and participation from all partners. Change occurs in three stages: collaboration, participation, and innovation, with additional steps in each stage. A principal component of the ARC model is a change agent who leads the transformation and training process for all involved parties such as staff, administrators, other service providers, and those implementing new programs.

Empirical evidence supports the use of ARC in the child welfare system. In a study in which the ARC intervention was randomly assigned to child welfare and juvenile case management teams, there was a significant decrease in the probability of turnover and a significant improvement in organizational climate as measured by emotional exhaustion, depersonalization, confusion on role, or too many roles (Glisson et al., 2006). Glisson and Schoenwald (2005) argue that this intervention is a key element for the effective implementation of evidence-based programs in human services. ARC has recently been used to assist in the implementation of Multi-systemic Therapy (MST) with delinquent youth in rural communities (Glisson & Schoenwald).

Residential providers have utilized similar change strategies. While taking part in an organizational shift toward culturally competent care, one child and family services organization identified a champion that reported to leadership (Cutler, 2008). They also recommend that organizations undergoing major transformations should assess for readiness by understanding the history and culture of the organization; identifying the level of willingness to change, what is motivating the change, and the commitment throughout the organization; realizing that there will be resistance; determining how leadership plans to invest in the process; and learning how change is created and sustained.

Other examples of organizational readiness strategies used by residential facilities that have undergone major changes include the use of Noer’s (1997) R-Factor Model, following Kotter’s Model of Change (Mind Tools, Ltd., 2009), and conducting a feasibility analysis (Martone, Connolly, Hatter, & McCarville, 2008). With regard to financing strategies, business plans that projected new expenses were seen as helpful, along with diversification of funding streams, and blending of funding. One agency felt that the active use of their strategic plan over several years was a strength as they moved ahead with transformation.

7. How will the quality of the program and/or initiative be assessed?

A process evaluation will assess how components of the model and selected strategies were implemented. For example, fidelity to the chosen model during implementation is a key factor in overall effectiveness of evidence-based practices. An assessment to determine if the critical elements of the evidence-based practice are being implemented across programs is
important as well (Jewell, McFarlane, Dixon, & Miklowitz, 2005), if residential providers choose to disseminate a practice among several agencies. Instruments with research behind them may be available to assess fidelity for programs. For example, the Wraparound Fidelity Index (WFI; Suter, Burchard, Force, Bruns, & Mehrtens, 2002) assesses if wraparound philosophy and principles are being carried out during implementation of the model. Other data such as the number of trainings offered to staff, family therapy attendance, number of family visits, staff contact with family members, and overall progress of the steps established in the plan (Step Number 6) will also demonstrate if the implementation is being carried out as intended.

Pluralistic evaluations capture and compare the perspectives of stakeholders involved in a service (Nolan & Grant, 1993). Multiple methods of data collection can increase the likelihood that broad perspectives and experiences will be identified. Residential facilities may want to consider quantitative outcome measurement combined with qualitative methods across a variety of stakeholders such as family, youth, funders, staff, board members, and other participating agencies. These additional methods may gather important information that would not be obtained through traditional quantitative data collection focusing strictly on youth and family outcomes.

8. **How well did the program work?**

   Qualitative and quantitative outcome data will determine the effectiveness of the program. Decisions will first need to be made on the evaluation methodology, such as whether comparison groups will be utilized. It is worth noting that many real-world settings choose to implement research-based practices without designating control groups within their setting, given the practical realities associated with control group evaluation methods (e.g., which typically involves excluding individuals from certain interventions the agency has decided to implement). The strengths and drawbacks to using a control group will need to be assessed. Outcomes will also need to be selected, along with their methods of measurement.

   Assessments of engagement, family-centered behavior, and various other engagement or family-centered principles such as empowerment will be essential. Such examples include the Family Empowerment Scale (FES; Koren, DeChillo, & Friesen, 1992), the Family-Centered Behavior Scale (FCBS; Allen, Petr, & Brown, 1995), the Measure of Process of Care (MPOC; King, Rosenbaum, & King, 1996), and a scale of client engagement developed with families receiving child protective services (Yatchmenoff, 2005). Dempsey and Keen’s (2008) review of measures used when researching family-centered care models for children with disabilities may also be a helpful resource. The types of outcomes desired will need to be explored among and within residential care centers, as well as whether standardized measurements such as the Child Behavior Checklist
(Achenbach, 1991) or academic performance will be used for measurement. In order to ensure reliable outcomes, an exploration of the psychometric properties of these scales will be necessary. An evaluation of the long-term effects of the program will also legitimize its strength in attaining outcomes. In regard to identifying processes for tracking outcomes, residential centers might want to consult with the Service Outcome Action Research Center for Youth and their Families (SOAR). Methods have been implemented by SOAR for evaluating outcomes in residential facilities in New York State.

9. How will Continuous Quality Improvement (CQI) strategies be incorporated?

The goal of CQI is to create organizational buy-in for ongoing review and commitment toward implementing necessary changes (Wiseman et al., 2007). A CQI strategy defines the method by which organizations will periodically review the data and information to assess progress on specific strategies. The CQI process can also serve as a mechanism to identify agency training and technical assistance needs. Programs will want to determine when and with whom CQI strategies will occur. A CQI plan often includes a review of the first eight steps of the GTO to assess for effectiveness, necessary changes, and a plan for instituting identified changes. The CQI strategies may already exist in general program procedures, such as the annual collection of parent and family satisfaction with each residential center or among all centers, or may be the result of an identified need such as monthly presentations to stakeholders requested by family participants. The role of CQI in change initiatives cannot be emphasized enough. If organizations use a theory of change and logic model process to commence implementation activities, the stage for CQI will be set. Through the process of clearly defining outcomes and strategies, organizations will be well positioned to identify information sources to assess progress. Through CQI, there is an established process to review information, determine if the strategy is moving the organization in the proper direction, and ultimately whether the strategy should be continued, enhanced, or discontinued entirely. These are critical components for change initiatives.

10. If the program is successful, how will it be sustained?

Sustainability includes maintaining organizational capacity and effectiveness in meeting the needs of those participating in the program (Wiseman et al., 2007). Organizations must internalize the core values and mission of the implemented program or strategy in order to maintain sustainability. Perspectives from staff, families, and key stakeholders, which may be gathered through CQI processes, will provide important information on methods for sustaining the program and building momentum. Additional staff and technology needs such as training curricula and evaluation are essential to meet long-term outcomes. The organizational capacity
to meet these needs must be determined. Infusing these needs into the infrastructure of a program as early as possible may more easily support long-term sustainability.

Clearly defined sustainability strategies must be defined early on in the change process to ensure that the organizational culture embraces, endorses, and continues to implement the change initiative. Although a successful program will likely attract funders, a clear plan during initial planning phases is necessary for long-term sustained funding. It is also critical that sustainability not be viewed in a purely financial manner. While funding is a key component to the ultimate outcome of remaining in business, for practice change initiatives, a key factor in sustainability is ensuring that the proper supports are in place to allow staff to maintain newly developed attitudes, beliefs and behaviors. Knowing what to sustain will be the byproduct of a strong evaluation and thoughtful CQI process. The information that results from these activities will not only inform what ought to be sustained, but will also provide critical information that can be used for marketing purposes or to solicit funding.

In summary, implementation of change initiatives is a highly complex process that requires a myriad of strategies and the involvement of multiple stakeholders. Regardless of the particular approach selected, it is evident that at the foundation of any successful practice change initiative is a structured process that is inclusive of key constituencies and clearly delineates the specific component or strategies. It is also critical that the change process effectively defines information needs and makes use of the information for evaluation CQI and sustainability.

**CONCLUSIONS**

This paper highlights practices of engagement within family-centered or family-driven models of care that are based on at least minimal levels of evidence, and makes recommendations based on the available information. Specifically, this paper proposes that residential facilities: (a) involve parents or guardians in active delivery of care within residential centers; (b) utilize system of care principles, particularly the wraparound approach and transition strategies; (c) integrate standardized assessment tools to identify specific variables that may alter the effect of family engagement strategies or family-centered interventions on outcomes; (d) implement evidence-based strategies that reduce initial barriers; (e) offer family therapy or parenting education to the extent possible; and (f) include parent mentors in the delivery of care. There is a dearth of research that connects specific components of family-centered care to outcomes and residential treatment centers.
Until more evidence is available, residential centers may want to explore the application of research-based programs that incorporate family-centered principles and engagement strategies in residential settings. Further, residential centers serve populations seeking various services for a variety of reasons which will make it necessary to choose models based on a needs assessment process.

The implementation of any change initiative requires thoughtful planning to ensure inclusion of the right people, selection of the right practices, development of the right measures and processes to assess and ultimately, determination if the right change was undertaken. A structured framework to conduct this work is essential and can be found within the theory of change and logic model process (Hernandez & Hodges, 2005). To implement family-centered practices, residential centers may want to consider an empowerment evaluation and Getting to Outcomes approach (Fetterman & Wandersman, 2005). This framework will support a thorough implementation of evidence-based practices based on identified needs and goals which will be realized for the long term. Several other strategies to enhance implementation, such as assessing for training needs and organizational readiness (Lehman et al., 2002), may also enhance implementation outcomes.

NOTE

1. It is important to note that there is considerable discussion in national policy arenas regarding how to define residential treatment. At times, this takes the form of debate over whether services provided in residential settings should be called residential treatment or residential care. This might be viewed as a frame of reference question referring to whether treatment is part of care, or care is part of treatment. Much of what occurs in residential settings for children constitutes basic care, such as food, shelter, and safety. However youth are placed in these facilities because their overall needs have not been met in other care settings (homes, foster homes, schools, etc.) and they need more specialized help or treatment. Sophisticated treatment interventions have also been referred to as care (e.g., System of Care communities around the country that serve children with serious mental and behavioral disorders). This discussion continues and is worthy of consideration.

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